Iowa CASA Advocate In-Service Training

Participant Guide

Independent Study

Iowa Child Advocacy Board

Trauma Informed Advocacy

Becoming a Trauma Informed Advocate to Build Resiliency

Introduction

The children we advocate for are victims of child abuse and neglect, and for no other reasons than that, have experienced trauma. Often the children we serve have experienced multiple traumas in their life, and at times these stem from the need to protect them and meet their needs. The system removes them from their family, their home, their pets, their friends, and even their school which can traumatize a child even further. Our goal as Advocates of these traumatized children is to support them and the system's efforts in healing from their trauma and having the family and children become resilient so that they may go on to have long lasting safety, permanency and well-being.

As a CASA Advocate, one of your roles is to provide a voice that is speaking up on the child's behalf, advocating for their best interests. We begin to fulfill that role when we advocate with a trauma informed lens and make recommendations that are aligned with the premise of "What happened to this person?" and NOT "What is wrong with this person?"

This training toolkit will provide you the opportunity to review and build upon what you discovered through Pre-Service Training related to trauma, ACEs, the brain, and protective factors to build resiliency.

Learning Objectives:

1. Become familiar with the definitions and types of trauma that children experience.
2. Identify how trauma impacts the brain, child development, and lifelong outcomes.
3. Describe how protective factors can build resiliency as the mechanism for advocacy of childhood safety, permanence and well-being.

Section One: Becoming Trauma Informed

Being Part of a Trauma-Informed Child Welfare System

A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.

(NSTSN Trauma-Informed Service Systems working group, 2012)

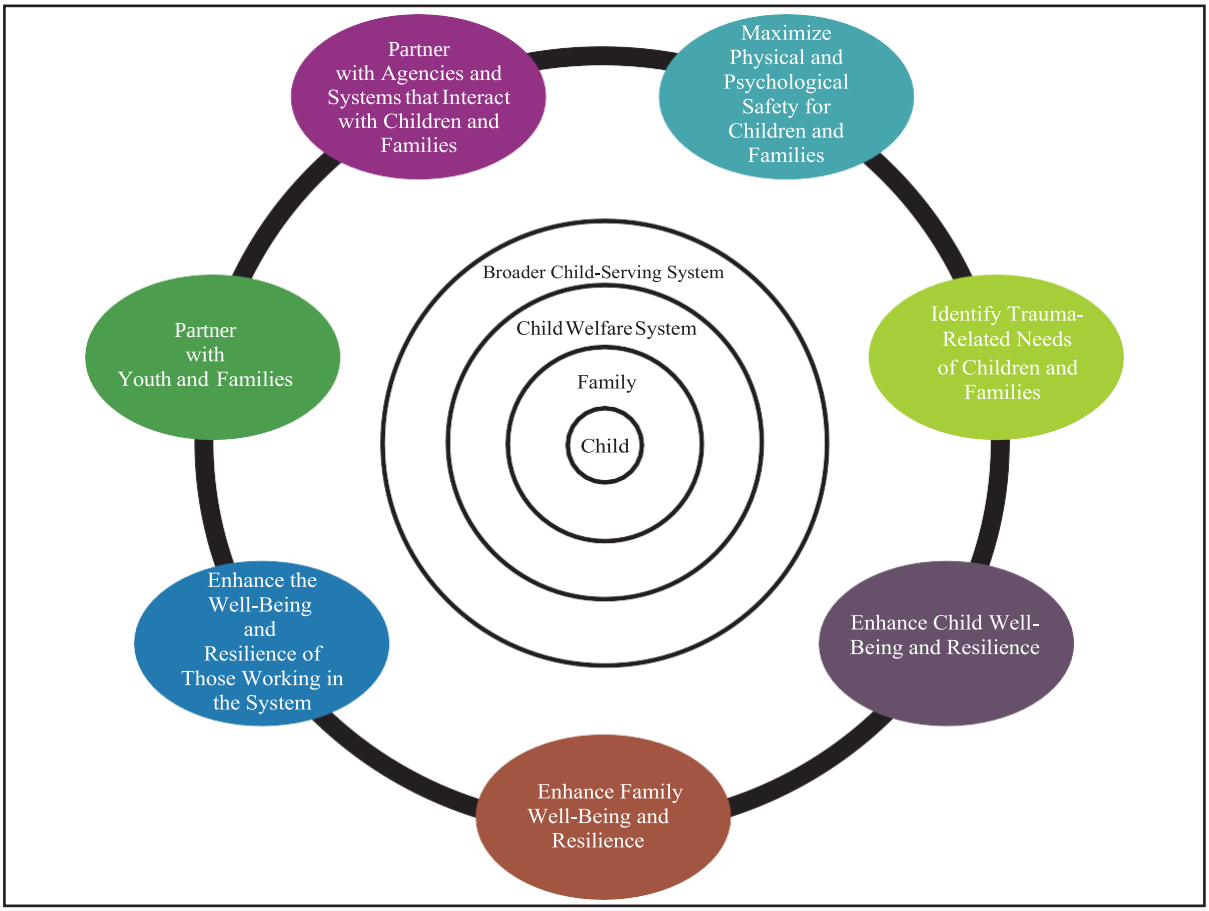
The research is clear that the experience of abuse or neglect leaves a particular traumatic fingerprint on the development of children that cannot be ignored if the child welfare system is to meaningfully improve the life trajectories of maltreated children, not merely keep them safe from harm.

Bryan Samuels, Commissioner for the Administration on Children, Youth and Families
Testimony to House Ways and Means Subcommittee on Human Resources, Congress (Samuels, 2011)

Simply removing a child from a dangerous environment will not by itself undo the serious consequences or reverse the negative impacts of early fear learning. There is no doubt that children in harm's way should be removed from a dangerous situation. However, simply moving a child out of immediate danger does not in itself reverse or eliminate the way that he or she has learned to be fearful. The child's memory retains those learned links, and such thoughts and memories are sufficient to elicit ongoing fear and make a child anxious. (National Scientific Council on the Developing Child, 2010)

Essential Elements of a Trauma-Informed Child Welfare System

1. Maximize physical and psychological safety for children and families
2. Identify trauma-related needs of children and families
3. Enhance child well-being and resilience
4. Enhance family well-being and resilience
5. Enhance the well-being and resilience of those working in the system
6. Partner with youth and families
7. Partner with agencies and systems that interact with children and families



Chadwick Trauma-Informed Systems Project. (2013). *Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model* (1st ed.) San Diego, CA: Chadwick Center for Children and Families.

Our First Step in Becoming a Trauma-Informed Advocate:

Understanding trauma and its impact on the children and the families in the child welfare system and how to advocate with a trauma-informed care (TIC) lens is a critical skill for CASAs. The Iowa Child Advocacy Board builds upon the Advocate's TIC core knowledge and skills gained during pre-service training by offering in-service training to enhance your advocacy efforts.

An integral piece of becoming trauma informed is recognizing that regardless of our own personal experiences, it is critical to practice good self-care. The Iowa CASA Program will provide training specific to advocate self-care. However, if as Advocates we have also experienced past traumas, we will need to be cognizant of our level of discomfort or distress as a result of completing this trauma material. Please practice healthy coping while completing this content by taking a break as needed, connecting with someone close to you, or informing your Coordinator you'd like self-care training materials prior to continuing this training module.

The initial section of the material we offer to our Advocates comes from Alberta Health Services of Canada.
https://www.albertahealthservices.ca/info/Page15526.aspx

Alberta Health Services

The content to complete for this required CASA Advocacy training is two sections from their online trauma training. There are six separate buttons for each module that Alberta Health Services offers, and each will link to the external hosting site. The modules we ask you to complete is **Module 1: What is Trauma Informed Care?** and **Module 2: What is Trauma?**

- Module 1: What is Trauma-Informed Care?
- Module 2: What is Trauma?
- Module 3: Disaster Response
- Module 4: Loss and Grief after Trauma
- Module 5: Trauma in Human Service Workers
- Module 6: Emotional Literacy

Modules 4, 5 and 6 can be completed for enhanced trauma-informed care advocacy. Please ask your Coordinator for more details on the enhanced learning, if interested.

Disclaimer on Alberta Health Services Content:

A portion of this content was developed to educate Canada's providers on the country's indigenous population. Statistics and data included are specific to that population in Canada. Native American information can be provided to you by your Local Coordinator if you are advocating for a child with Native American heritage.

Before you get started, below is information for your best online learning experience.

Please ensure the computer meets the minimum system requirements:

- Operating System: minimum Windows 7
- Internet Explorer (IE) 8 (or higher) or Google Chrome; Firefox may also be used*
- Current version of Adobe Flash is required

*Some learners have experienced issues using Firefox. If using IE, the most recent version of the browser will give the best results.

The module will ask for you to fill in your name. This is not for long-term storage but to auto generate your certificate of completion when you are finished with the online training.

You may pause or stop the training, so you can return to it at a later time. It provides the opportunity to resume where you left off.

Please use the link above, or below, to go to the website to complete Module 1: What is Trauma-Informed Care?
https://www.albertahealthservices.ca/webapps/elearning/TIC/Mod01/story_html5.html

Module 1 Course Information

Learning Objectives: Participants will be able to:

1. Describe what trauma-informed care is.
2. Identify your role in trauma-informed care.
3. Describe what trauma is.
4. Describe the principles that guide trauma-informed care.
5. Reflect on what you could do to engage in TIC within your role.

Following completion of the Module 1 online portion of this training, you will be able to download your completion certificate. Please save this as you will send it to your Coordinator in order to receive your in-service credit.

Next, please use the link below, to go to the website to complete Module 2: What is Trauma?
https://www.albertahealthservices.ca/webapps/elearning/TIC/Mod02/story_html5.html

Module 2 Course Information

Learning Objectives: Participants will be able to:

1. Describe what psychological trauma is.
2. Identify types of trauma.
3. Identify characteristics of trauma.
4. Demonstrate understanding of neurobiological processes involved in trauma.

5. Describe symptoms of Post-Traumatic Stress Disorder.
6. Describe processes involved in post-traumatic growth.

Following completion of the Module 2 online portion of this training, you will be able to download your completion certificate. Please save this as you will send this to your Coordinator in order to receive your in-service credit.

Continuation of Learning to Become a Trauma-Informed Advocate

This next section includes a recap of the content in the online training, along with more detailed information to support advocacy efforts for children. The video links in the boxes illustrate the content. We provide this trauma and resiliency content to you in a written format to support future reference to this important material. The Section Two Resiliency material (page 51) is not included in the online training but is critical information for your role.

Trauma is defined as:

*Witnessing or experiencing an event that poses a **real or perceived** threat to the life or well-being of the child or someone close to the child.*

*The event **overwhelms the child's ability to cope** and causes feelings of fear, helplessness, or death.*

The experience of trauma can be explained through common elements known as the "Three E's": event, experience, and effects. These elements address the uniqueness of the individual's response to an event and how that event affects one's future behavior and well-being.

Situations or Events That Can Be Traumatic Include:

- Physical or sexual abuse
- Abandonment, betrayal of trust (such as being abused by a caregiver), or neglect
- The death or loss of a loved one
- Life-threatening illness in a caregiver
- Witnessing domestic violence
- Automobile accidents or other serious accidents
- Bullying
- Life-threatening health situations and/or painful medical procedures
- Witnessing or experiencing community violence (e.g., drive-by shooting, fight at school, robbery)
- Life-threatening natural disasters
- Acts or threats of terrorism

The experience of the event, or series of events, is subjective in nature as it relates to how someone reacts to an event and that can vary among people and over time. The way one person experiences an event might differ from the way another person does; culture, gender, and age all influence one's experience of the event. Additionally, people experience events in different ways. Resilience, risk and protective factors, and supports may contribute to this experience.

The effects are the reactions and the ways the experience changes or alters a person's ongoing and future behavior and well-being. This toolkit explores these effects in more detail, so we can begin to look at how we advocate to address the issue in the child's best interest.

What We Know and See in Child Welfare Related to Trauma

- Children under age four experience the highest rates of child maltreatment, and, even more specifically, *infants under age one account for a full 20% of the child welfare population in the United States*.

- Infants are particularly vulnerable to child abuse and neglect and are the age group most likely to be killed as a result.
- Many children who are removed from their family experience "double trauma," not only because of the abuse or neglect which brings them into the child welfare system, but also from the often-terrifying transition of being removed from their home. (Known as System-Induced Trauma)
- Children who experience trauma are also more likely to have parents who have experienced trauma themselves—making trauma an "intergenerational issue."
- Most children who are removed from their parents' custody are actually returned to their biological families at a later point.

Clearly, we can't just assume that removing a child from his or her home will "solve" the problem of traumatic experiences. What we can do is understand the types of trauma that children experience and how it affects the child, so we can effectively address its impact.

Types of Trauma

Acute trauma is a single traumatic event that is limited in time.

Examples include:

- Serious accidents
- Painful medical treatment
- Community violence
- Natural disasters (e.g., earthquakes, wildfires, floods)
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., being shot or raped)

During an acute event, children go through a variety of feelings, thoughts, and physical reactions that are frightening in and of themselves and contribute to a sense of being overwhelmed.

Chronic trauma refers to the experience of multiple traumatic events. These may be multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—OR long-standing trauma such as physical abuse, sexual abuse, neglect, or war.

The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact.

Complex trauma describes both exposure to chronic trauma—usually caused by adults entrusted with the child's care—and the impact of such exposure on the child.

Children who experienced complex trauma have endured multiple interpersonal traumatic events often from a very young age.

Historical trauma is a personal or historical event or prolonged experience that continues to have an impact over several generations.

Examples include:

- Slavery
- Removal from homelands
- Relocation
- Massacre, genocide, and ethnocide
- Cultural and racial immigrant oppression
- Forced placement in boarding schools

Neglect as trauma is a complex trauma that has profound effects on nearly every aspect of a child's development and functioning.

- Failure to provide for a child's basic needs
- Perceived as trauma by an infant or young child who is completely dependent on adults for care
- Opens the door to other traumatic events
- May interfere with a child's ability to recover from trauma

Child Traumatic Grief (CTG) is when someone important to the child dies in a sudden or violent manner that is perceived as traumatic to the child. The child's trauma symptoms interfere with his/her ability to grieve.

Symptoms of CTG include:

- Being overly preoccupied with how the loved one died
- Reliving or re-enacting the traumatic death, which may include play that incorporates themes related to the death
- Showing signs of emotional and/or behavioral distress when reminded of the loss
- Attempting to avoid physical reminders of the traumatic death, such as activities, places, or people related to the death
- Withdrawing
- Showing signs of emotional constriction or numbing
- Showing signs of a lack of purpose and meaning to one's life

Medical trauma is related to ongoing or chronic illness or injury. This is a special concern for children in foster care due to their higher rates of chronic health issues. Children are at risk for additional traumatic stress reactions related to their healthcare experience.

Risk factors for persistent traumatic stress in all ill and injured child are particularly relevant for children in foster care due to:

- Experiencing severe levels of pain during illness or injury
- Exposed to scary sights and sounds in the hospital
- Are separated from parents or caregivers during treatment
- Have experienced prior medical trauma or had previous trauma reactions

For children in foster care, medical trauma may become "layered" onto previous traumatic experiences.

Other Sources of Ongoing Stress Children in the child welfare system frequently face other sources of ongoing stress that can challenge the ability to effectively intervene. Some of these sources of stress include:

- Poverty
- Discrimination
- Separations from parent/siblings
- Frequent moves
- School problems
- Traumatic grief and loss
- Refugee or immigrant experiences

Child Traumatic Stress refers to the physical and emotional responses of a child to events that threaten his or her life or physical integrity or that of someone critically important to the child (such as a parent or sibling).

Traumatic events elicit feelings of terror, powerlessness, and out-of-control physiological arousal, and overwhelm a child's capacity to cope. Child traumatic stress reactions (post-traumatic stress reactions) include re-experiencing the event through intrusive memories; nightmares or flashbacks; avoidance of trauma reminders; heightened arousal (being "on edge", jumpy, or hyperalert); and persistent difficult thoughts and emotions like guilt or shame.

Advocates begin their trauma-informed journey by becoming familiar with the terminology. Being an expert on trauma is not necessary, however.

How Does Trauma Affect Children?

Children's responses to traumatic events can have profound, long-term effects on the way they view themselves, others, and the world and their future.

Traumatic events may affect a child's trust and sense of safety and may make them more vulnerable to current and future stressors.

Traumatic Events

Traumatic events affect a child's

- Ability to trust others
- Sense of personal safety
- Effectiveness in navigating life changes

There is variability in responses and impact to stressors and traumatic events by both:

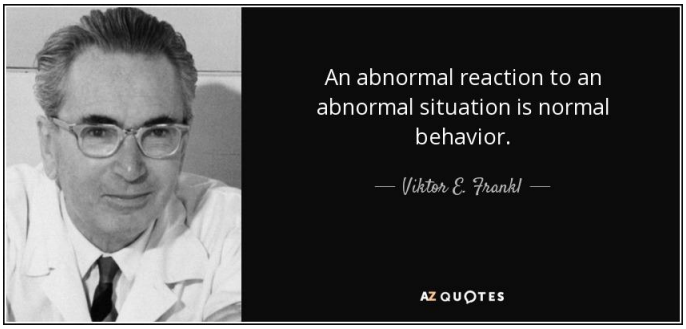
- The objective nature of the event
- The child's subjective response to it

Something that is traumatic for one child may not be traumatic for another.

What is the Impact and Effect of Trauma?

A brief summary of trauma's effect/impact is this:

It is a normal response to an abnormal situation.



It can have both short and long-term effects, with an impact that may not be immediately recognized.

It can affect the individual's coping responses or ability to engage in relationships, OR it can interfere with the mastery of developmental tasks.

It may affect an individual's physiological responses, psychological well-being, social relationships, and/or spiritual beliefs.

The impact of a potentially traumatic event depends on several factors, including:

- The child's age and developmental stage
- The child's perception of the danger faced
- Whether the child was the victim or a witness
- The child's relationship to the victim or perpetrator
- The child's past experience with trauma
- The adversities the child faces following the trauma
- The presence/availability of adults who can offer help and protection

When trauma is associated with the failure of those who should be protecting and nurturing the child, it has profound and far-reaching effects on nearly every aspect of the child's life.

Children who have experienced the types of trauma that precipitate entry into the child welfare system typically suffer impairments in many areas of development and functioning, including:

Biology: Children impacted by trauma may experience changes in brain chemistry and structure and higher levels of stress hormones. They may show hypersensitivity to physical contact. Many of these children exhibit unexplained physical symptoms and increased medical problems.

Attachment: Trauma-exposed children may feel that the world is uncertain and unpredictable. They can become socially isolated and can have difficulty relating to and empathizing with others.

Mood regulation: Children exposed to trauma can have difficulty regulating their emotions as well as difficulty understanding and describing their feelings and internal states.

Dissociation: Trauma-exposed children may experience a feeling of detachment or depersonalization, as if they are observing something happening to them that is unreal.

Behavioral control: Children who have been traumatized can show poor impulse control, self-destructive behavior, and aggression towards others.

Cognition: Children exposed to trauma can have problems focusing on and completing tasks, or problems planning for and anticipating future events. Some exhibit learning difficulties and problems with language development.

Self-concept: Trauma-affected children frequently suffer from disturbed body image, low self-esteem, shame, and guilt.

Development: Trauma can disrupt developmental processes and interfere with the mastery of age-appropriate tasks and skills.

Trauma and Overwhelming Emotion and Behavior

Trauma can elicit such intense fear, anger, shame, and helplessness that the child feels overwhelmed. Overwhelming emotion may interfere with the development of age-appropriate self-regulation. Emotions experienced prior to language development may be very real for the child, but difficult to express or communicate verbally. Trauma may be "stored" in the body in the form of physical tension or health complaints.

Trauma-exposed children may also exhibit:

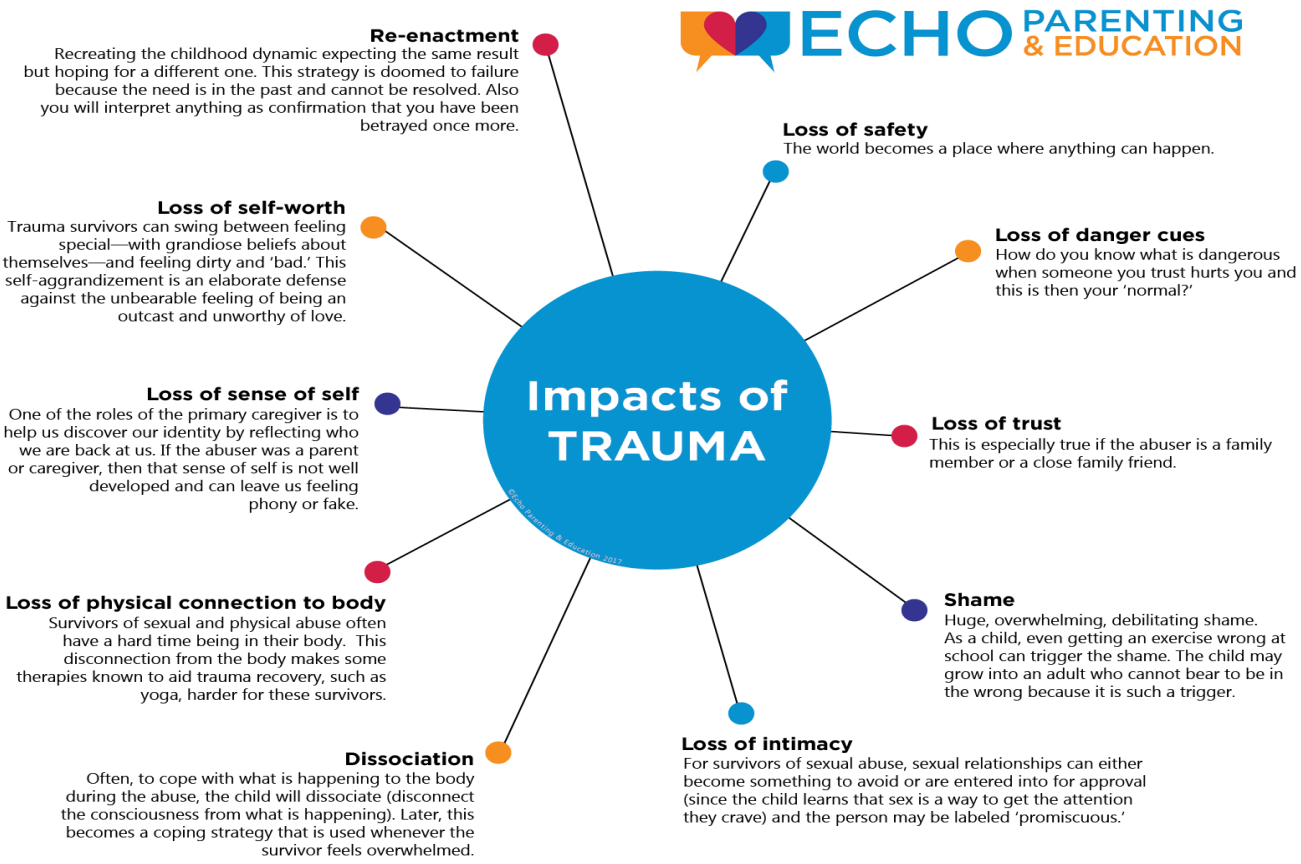
- Over-controlled behavior, in an unconscious attempt to counteract feelings of helplessness and impotence, may manifest as difficulty transitioning and changing routines, rigid behavioral patterns, repetitive behaviors, etc.
- Under-controlled behavior, due to cognitive delays or deficits in planning, organizing, delaying gratification, and exerting control over behavior, may manifest as impulsivity, disorganization, aggression, or other acting-out behaviors.

Trauma-exposed children's maladaptive coping strategies can lead to behaviors that undermine healthy relationships and *may disrupt foster placements*, including:

- Sleeping, eating, or elimination problems
- High activity levels, irritability, or acting out
- Emotional detachment, unresponsiveness, distance, or numbness
- Hypervigilance, or feeling that danger is present even when it is not
- Reckless or self-destructive behaviors

- Increased mental health issues (e.g., depression, anxiety)
- An unexpected and exaggerated response when told “no”

Please visit link to view larger image. http://www.echoparenting.org/the-impact-of-trauma/

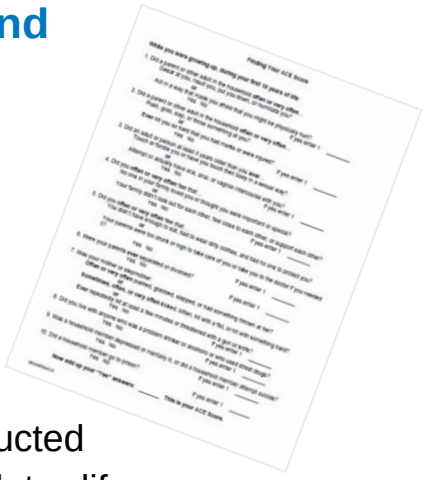


Long-Term Effects of Childhood Trauma

In the absence of more positive coping strategies, children who have experienced trauma may engage in high-risk or destructive coping behaviors. These behaviors place them at risk for a range of serious mental and physical health problems, including:

- Alcoholism
- Drug abuse
- Depression
- Suicide attempts
- Sexually transmitted diseases (due to high-risk activity with multiple partners)
- Heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease

Adverse Childhood Experiences – ACE Study and its Impact



One study that pinpoints the effects of trauma, or toxic stress on the long-term health of an individual, is the Adverse Childhood Experiences, or ACE, study first conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente in 1995-1997.

The ACE Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study identified specific experiences that put children at risk for negative outcomes in adulthood. The specific experiences identified include things like domestic abuse, emotional abuse, sexual abuse, parental drug use, physical abuse and criminal behavior in the household. Each category of experiences was scored on the ACE survey of over 17,000 educated, middle class, and predominantly white adults.

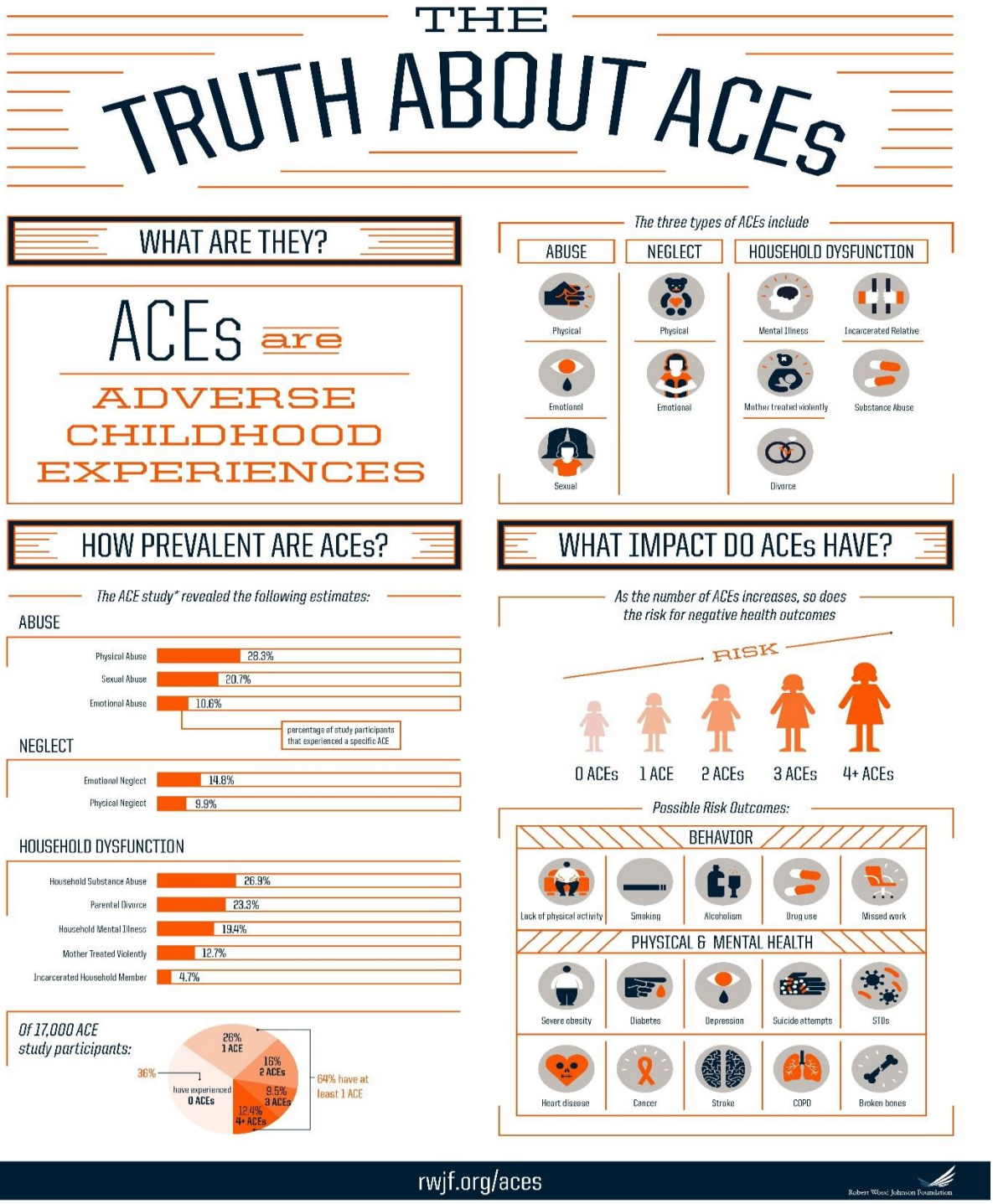
The ACE Study suggests that these identified experiences are major risk factors for the leading causes of later illness and death, as well as poor quality of life. In addition, the ACE study showed a very strong correlation between the number of ACEs experienced in childhood, and poor adult outcomes. These outcomes were found across many domains, including:

- Physical health
- Mental health
- Risk behaviors
- Socioeconomic status

It's also important to note that when children experience **four of more** of these ACE factors together, their risk for issues in adulthood increases exponentially.

The framework for understanding these health and life issues became more than the common-sense explanation that unresolved trauma will lead to maladaptive coping behaviors. We know now that trauma can truly alter your DNA.

****Extended Learning Activity:** Please watch the 15-minute Ted Talk video of Nadine Burke Harris *"How childhood trauma affects health across the lifetime."*
https://youtu.be/95ovIJ3dsNk



*Source: http://www.cdc.gov/ace/prevalence.htm

Key Points about Adverse Childhood Experiences and the ACE study:

- **They are common.** 1/3 of the people in the study had an ACE score of 0. That means that 2/3 had an ACE score of 1 or more.
- **High ACE scores are not uncommon.** More than one in five (22%) reported three or more ACEs.
- **They tend to occur in clusters and are interrelated.** Some types of childhood trauma tend to involve multiple ACEs. For example, in a family where there is domestic violence, there often exists additional problems such as substance abuse, drug use, separation/divorce, physical abuse, sexual abuse, someone in the correctional system, abandonment, etc. The study found that if any ACE is present, there is an 87% chance at least one other category of ACE is also present.
- **They impact health issues in the same pattern**. As the number of ACEs increases, so does the risk for health problems in a strong and graded fashion.
- **It is the cumulative effect of the ACEs that impacts the person and their outcomes.** It is the number of different categories not the intensity or frequency of the ACEs that determine the health outcomes.

- **They are intergenerational.** Traumatized children grow into traumatized parents who have traumatized children.
- **ACE score of 4 or more** results in multiple risk factors for the diseases or the disease themselves.

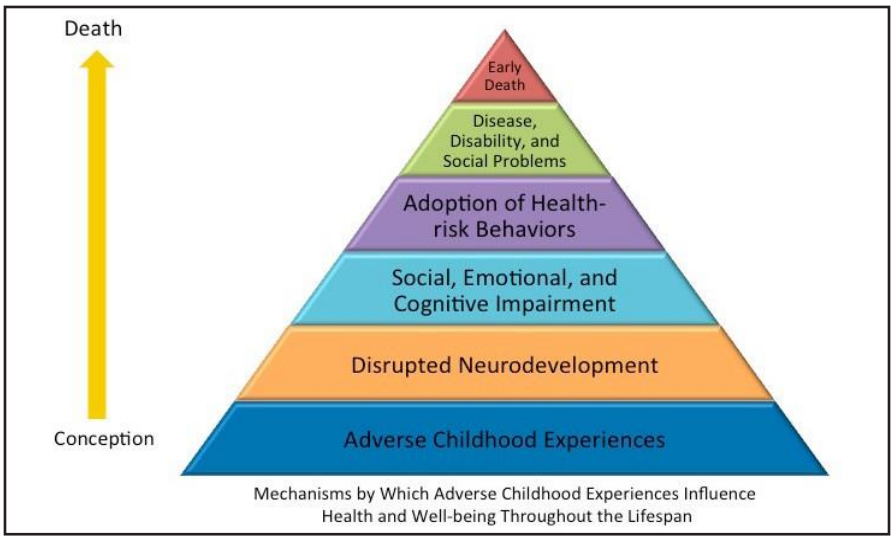
- **ACE score of 6 or more** may result in a 20-year decrease in life expectancy.
- **Individuals will strive to cope with their experiences.** Some of the coping solutions might be helpful, others negative. Often, the negative behaviors are also functional for the person. They help the person survive and move forward. Even though the behaviors

may be destructive and damaging, they also may be effective in helping people function.

- **A major factor, if not the main factor, underlying addiction is ACEs.** Unhealed trauma that is concealed from awareness and society by shame, secrecy and social taboo influences unhealthy coping behaviors.

- **Not all individuals who experience ACEs are destined to have these negative outcomes.** We can learn and incorporate those factors that mitigate the negative impact of ACEs.

Long-Term Trauma Impact—ACE Pyramid: CDC (http://www.cdc.gov/ace)



****Activity:** Please watch the 8-minute video, *"Personal and Parental Reflections on Adverse Childhood Experiences"* https://youtu.be/jUJHvbPrL0I

For more information about the ACE study in Iowa and to find other useful resources and website links, go to:

- http://www.iowaaces360.org/
- http://www.acestudy.org/the-ace-score.html
- https://www.cdc.gov/violenceprevention/acestudy/index.html
- https://acestoohigh.com/

How Can We Use the ACEs Information?

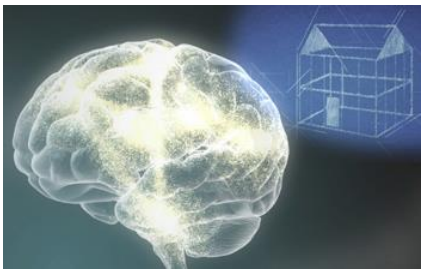
To apply our increased understanding of ACEs' significant impact to our advocacy efforts, every CASA Advocate will assess the ACEs score of every child we are appointed to serve. Our goal is that no child will experience an increase in their ACE score while receiving advocacy efforts of the CASA program. Your coordinator will discuss this further during your in-person segment of this trauma training.

Understanding the Science Behind the Trauma

In order to fully understand the impact of trauma on a child, it is critical to turn to science. A growing body of neuroscience informs our work in a number of ways. First, we have become increasingly aware that the majority of brain growth and synaptic development takes place before a child turns three years old. We also know and will explore further the fact that early experiences can have a profound experience on brain architecture. While the early years are important for establishing a strong foundation for development, we also need to remember that our brains continue to develop and be shaped throughout our life, and that in adolescence in particular, we see specific changes in the brain which profoundly impact behavior.

What Makes Trauma or ACEs So Harmful?

The Harvard Center on the Developing Child states that "a toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support."



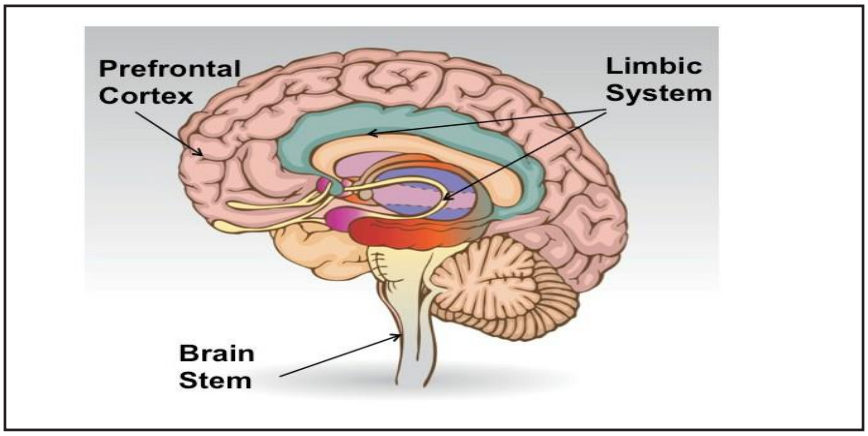
Why exactly are children so dependent on caregivers as stress buffers? Because their brains simply aren't

developed to the point where they can "take care of themselves," or respond to stress with more "adult" coping mechanisms.

So, it all begins with understanding a child's developing brain.

Brain Structure: Three Main Levels

1. Brainstem/midbrain – autonomic functions (e.g., breathing, eating, sleeping, feeling pain)
2. Limbic system – emotional regulation and memories, value of emotion
3. Cortex – abstract thought, logic, factual memory, planning, ability to inhibit action



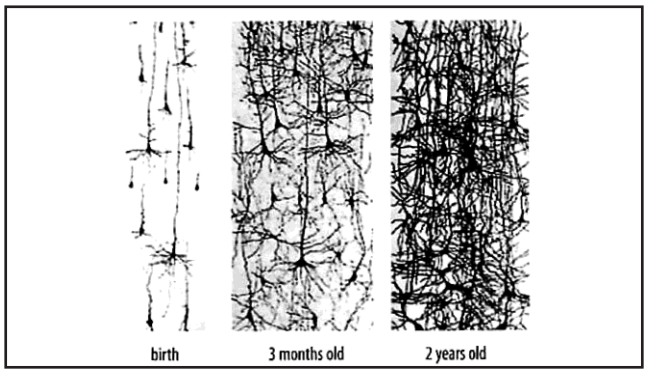
Experience Grows the Brain

- Brain development happens from the bottom up:
- From primitive (basic survival: Brainstem) to more complex (rational thought, planning, abstract thinking: Prefrontal Cortex)
- The brain develops by forming connections.
- The more an experience is repeated, the stronger the connections become.
- Interactions with caregivers are critical to brain development.

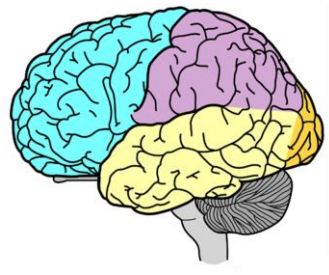
****Activity:** Please watch the 2-minute video, *"Part 1: Experiences Build Brain Architecture"* from the Center on the Developing Child at Harvard University.
https://youtu.be/VNNsN9IJkws

Brain Development

- The prenatal brain has 2-3 times the number of adult nerve cells as the adult brain.
- The maximum number of nerve cells is present at birth.
- Brain growth (size and weight) over the first years of life is due to:
  - Myelination: the process that allows nerve impulses to move more quickly
  - An increase in synaptic connections: how nerve cells communicate with other cells



- The growth of the brain is dependent on stimulation and experience
- The brain has relatively few synapses (connections between the brain cells) present at birth.
- Learning requires forming new synapses as well as strengthening and discarding existing synapses.
- Early synapses are weak and need repeated exposure to strengthen.
- The brain adapts to environment, both positive and negative.



The Importance of Starting Early

As Brazelton and Greenspan wrote in 2000, “Early childhood is both the most critical and the most vulnerable time in any child’s development. In the first few years, the ingredients for intellectual, emotional and moral growth are laid down. We cannot fail children in these early years.”

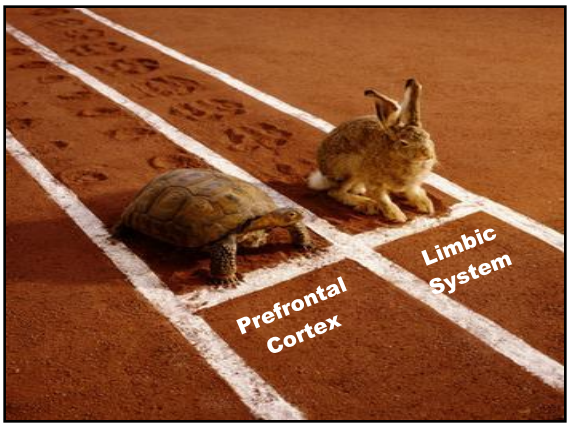
For children, optimal brain development is highly dependent on access to a nurturing caregiver. Early brain development has a reciprocal relationship with certain experiences based on the caregivers’ ability to provide:

- Consistent attention,
- Nurturing care, and
- Reinforcement of learning.

A child's relationship with his or her parents or caregivers plays a huge role in shaping the developing brain through a process called "serve and return." Like in games such as tennis and volleyball, young children naturally reach out for interaction through babbling and facial expressions and adults respond by doing the same kind of vocalizing and gesturing back at them.

**Activity: Please watch the 2-minute video, *"Part 2: Serve and Return Interactions Shapes Brain Circuitry"* from the Center on the Developing Child at Harvard University. https://youtu.be/m_5u8-QSh6A

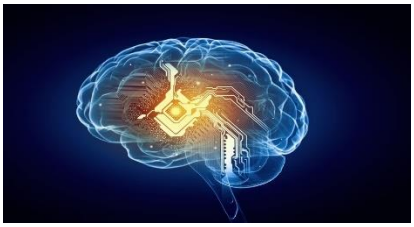
Developmental Gap in Adolescent Brains



One of the key takeaways from the research is that adolescence represents the second great wave—after the first few years of life—of brain growth and development. Contrary to long standing beliefs—the fact is that the brain is not "fully cooked" at age 3. While early experiences affect the quality of the brain's architecture, adolescence presents another period where experiences and support can help with the rewiring of the brain and the creation of new neural pathways. It's a period of remarkable opportunity.

So, if you've ever wondered why adolescents act the way they do—this your answer! It's all about the brain! The prefrontal cortex, which controls such things as impulse control, setting priorities, decision making, self-control, self-regulation—matures gradually and isn't fully developed until around age 26. At the same time there are rapid changes in the limbic system which controls such thing as:

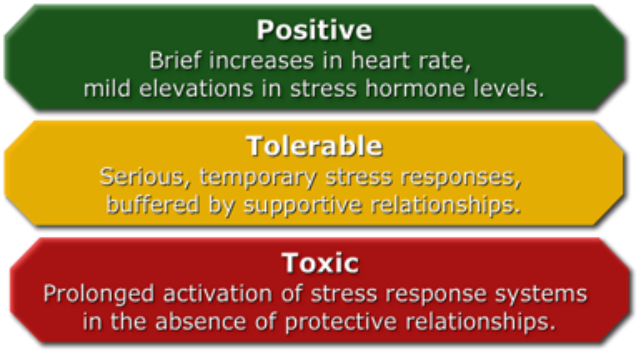
- emotionality
- reward/pleasure seeking
- processing social information



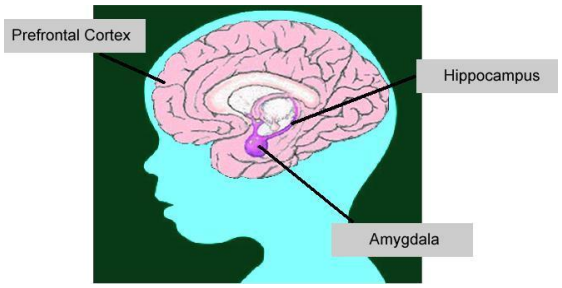
So, this gap in the timing of gradual prefrontal cortex maturation and more rapidly developing limbic system is responsible for the kind of bewildering and often infuriating behavior that has vexed parents since the beginning of time.

What Derails Healthy Brain Development?

According to the Harvard Center on the Developing Child, while moderate, short-lived stress can promote brain growth, toxic stress weakens the architecture of the developing brain. Remember, toxic stress can occur when a child experiences strong, frequent, and/or prolonged adversity without adequate adult support.



The prolonged activation of the stress response system can disrupt brain development and other organ systems and take a cumulative toll on a person's physical and mental health for a lifetime. Thus, ACEs can impact the brain development, and impacts it at every stage of brain development.

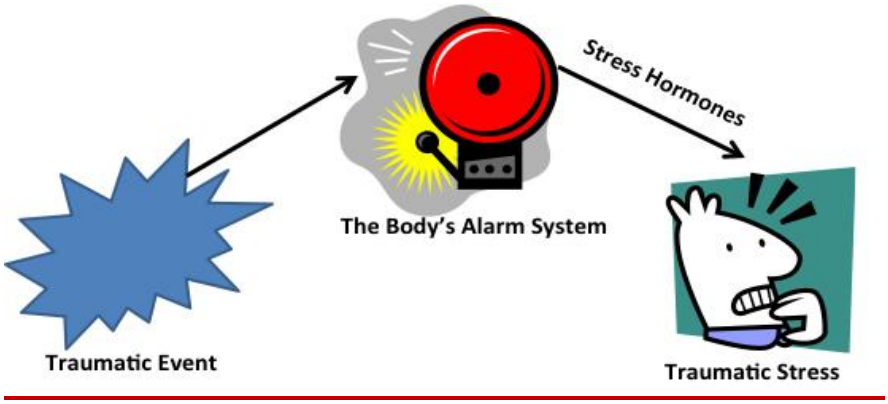


When a child is under stress or experiences a traumatic event, the amygdala acts like an "alarm system," overriding the hippocampus' ability to process and the prefrontal cortex's ability to think. When stress hormones saturate our body, we experience increased heart rate, hyper-vigilance, confusion, rapid breathing, numbness, chills, fear, and/or terror — this is often described as "fight or flight". This allows us to react quickly and automatically in dangerous situation. However, this amygdala-hippocampus-prefrontal cortex system can fall apart when a child experiences extreme, repeated, or unrelieved stress or trauma.

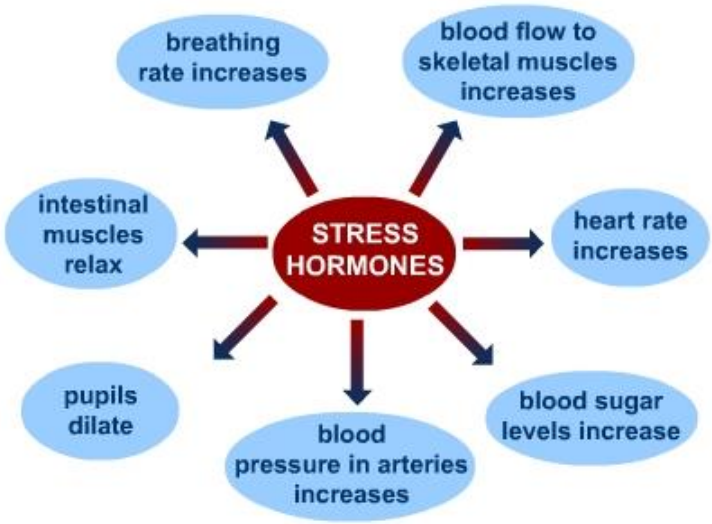
Traumatic Stress Response Cycle

Think about this: What happens when we hear an alarm go off? Now what happens when that same alarm just keeps on going off over and over

again? Stress is like our body's alarm system. It is supposed to help us respond quickly in ways that will help keep us safe. But when we experience too much stress without relief—it's like an alarm that keeps going off—eventually we can't respond to it the way we should.



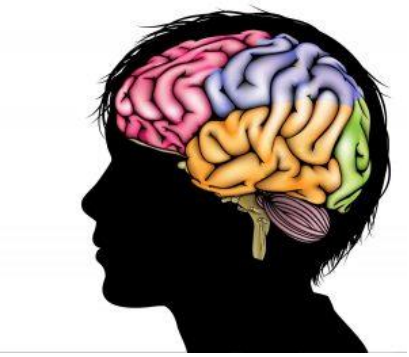
Stress hormones—particularly dopamine, norepinephrine, and epinephrine—are released into the body in response to the traumatic event.



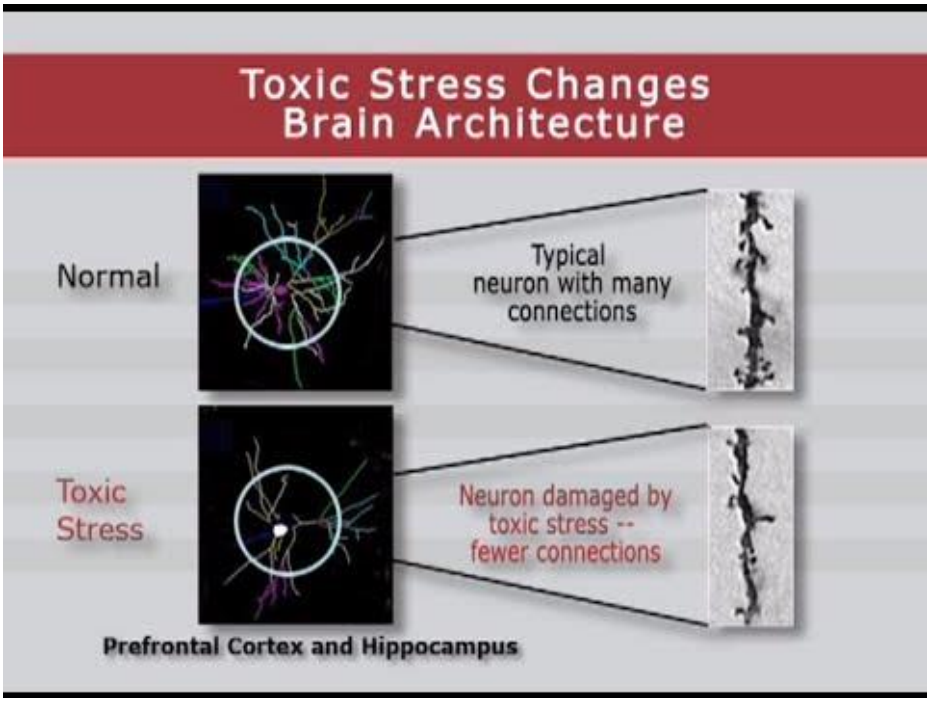
If enough of these stress hormones are released for a long enough period of time, they cause the child to experience traumatic stress.

Traumatic stress is marked by lasting changes to the body's stress response system. This may include a consistent "alert" mode, whereby the child becomes hyper-vigilant and his or her resting heart rate remains heightened **even after the threat has been removed**.

In other cases, in response to prolonged exposure to stress hormones, the body adapts and becomes less responsive. Stress hormones also suppress the frontal brain region's enduring ability to support memory, concentration, inhibition and rational thought. Thus, development of higher brain functions impact how the child will interact with the world and their ability to be successful navigating the complexities of life.



Over time, if a child is chronically exposed to toxic stress, this brain-neurotransmitter system becomes permanently dysregulated, meaning that the system can be stuck perpetually in overdrive—leading to consistently over-activated feelings of stress, alarm, anxiety and fear. What this means for brain architecture is that prolonged stress will eventually change the brain.



Activity: Please watch the 2-minute video, *Part 3: Toxic Stress Derails Healthy Development* from the Center on the Developing Child at Harvard University.

https://youtu.be/rVwFkcOZHJw

The Science of Neglect

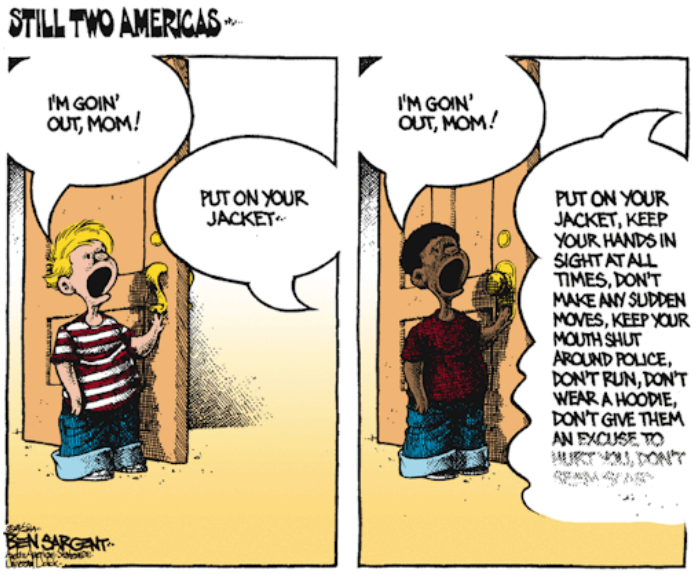
As the toxic stress video discussed, neglect can also activate the stress response system. While media and other attention tends to focus on the problem of abuse, what the research shows is that chronic neglect can have more lasting and harmful effects than physical abuse. This is because the interaction between a child and a caregiver is such a fundamental developmental building block. The good news, however, is that the impact of neglect can be mitigated by a combination of therapeutic interventions and highly supportive care.

****Activity:** Please watch the 6-minute video, "*The Science of Neglect*" from the Center on the Developing Child at Harvard University. https://youtu.be/bF3j5UVCSCA

A more thorough in-service training on child neglect specifically, can be provided at a later date.

Chronic Environmental Stress

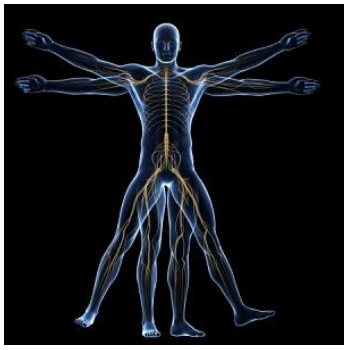
It's important to remember that chronic stress isn't just caused by abuse or neglect. As this cartoon illustrates, chronic stress can also come from the environment.



This is why children who are faced with continuous racism, oppression or environmental safety concerns, like war or violent gang activity, can also experience traumatic stress responses.

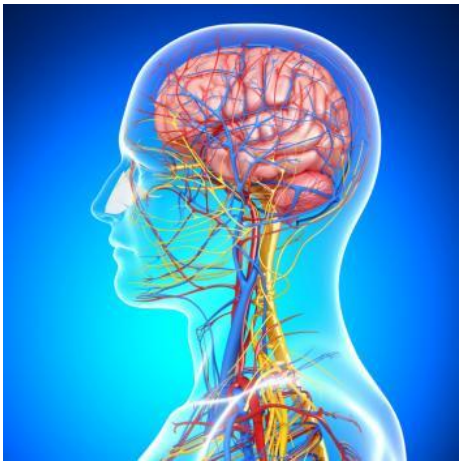
Specific Neurological Framework

We have shown how the neurobiological impact of trauma, or ACEs, or toxic stress can impact the body. When toxic stress occurs early in development, the functioning of all three highly integrated systems of our body: the immune system, the neuroendocrine system, and the central nervous system, are all affected. Specifically, there is an:



Increase in:

- Size of amygdala (increased interpretation of stimuli as fearful)
- Sympathetics NS (fight/flight/freeze)
- Startle response
- Cortisol levels (stress hormones)
- Inflammation
- Blood pressure, resting heart rate, respiration
- Weight gain
- Trembling/shaking
- Kindling of HPA axis (takes less stress to trigger a stress response)

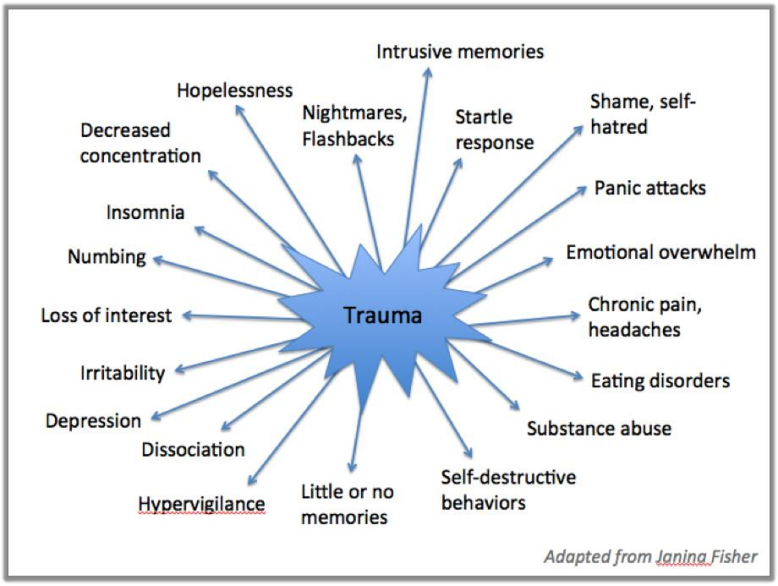


Decrease in:

- Hippocampa volume (learning and memory)
- Corpus callosum volume (smaller, fewer connections, less integration)
- Cortex / brain volume (smaller brain)
- Short-term memory
- Verbal recall
- Parasympathetic NS (calming system)
- Ability to form attachments
- Ability to regulate mood and affect

This impaired neurobiology influences behaviors such as:

- Withdrawal from social activities or isolating self from others
- Substance use
- Early intercourse, promiscuity
- Problems with anger
- Somatic issues such as sleep disturbances
- Distrust of adults
- Unable to develop healthy peer relationships
- Struggle with learning; falling behind in school
- Short attention span



One important part of your CASA Advocate role is to understand the degree of trauma, or the ACE score of the child you are advocating for at the time of case assignment. We track that score in our data system so that we can then monitor the impact of those ACEs on their functioning, make recommendations to mitigate the effects of the trauma, and advocate that no additional ACEs occur in the child's life while receiving advocacy services from a CASA Advocate.

Recognizing Trauma Impacts on the Children We Serve: Our Next Step in Becoming a Trauma-Informed Advocate.

CASA Advocates are not diagnosticians, therapists, or service providers. CASAs are in place to observe and report objective information and to make recommendations for what is best for the children based on that information. To do this effectively, it is important to have a baseline understanding of how trauma impacts children across all ages.

Trauma Triggers

One of the first important areas in which a CASA can observe the impact of trauma in the "here and now", is when the child is reminded about the trauma. Have you ever observed or read a report about a child who had an extremely over-the-top response to the littlest thing; whose response was so disproportionate to the activity, that you had to ask yourself, "What is going on?" Many times, responses that don't match the event are a response to what is known as a "trauma trigger."

Simply put, trauma triggers are reminders about past traumatic events that cause people to want to protect themselves and sets off the body's alarm system, so that the person feels in imminent danger once again. The triggers are related to a trauma memory and can be things we hear, see, feel, or even smell. These "triggers" can be anything connected to a traumatic event, including a similar type of an event, the situation, place, time of year, physical sensation, or even a person. Our brain recognizes these triggers because when, in the past, we saw, heard, or felt that way, it meant we needed to act quickly in response to a danger or threat.

There are many ways children who have experienced trauma might be triggered. Sometimes the triggers are easy to identify and, as Advocates with background information about the child and the case issues, we might be able to conceptually connect the trigger to the traumatic memory. Other times, the trigger may seem completely unrelated to the traumatic memory, leading us to wonder how the two are connected.

For example:

You, and the child you are visiting/advocating for, are walking down the street when a car backfires. The loud crack may startle you and cause you to look around curiously. But then you notice that the child you are with has fallen to the sidewalk, curled into a ball as tight as he can make himself, and is covering his head with his arms. As the adult, the response to a trigger may not make any sense, because the same alarm is not going off for you. You hear a car backfire and can very quickly assess that you are in no danger; but the loud crack triggered a painful and traumatic memory for the child and he instantly moved to protect himself.

This trigger response is relatively easy to identify by the loud sound of a car backfiring.

Another example:

You spoke with the foster parent and heard about an incident at the family table last night. The foster mother decided to serve green beans for dinner. When the green beans were put on the table, the child had a total meltdown—yelling, crying, and rolling on the ground. The response seems over the top and out of the norm. You later find out that green beans were often served for dinner in a home where the child was mistreated and uncared for.

Final example:

You and the child are in the park sitting on a bench with the foster parent nearby. Another person walks by you both with an energetic puppy that is eager to play. The child becomes terrified, clingy, and will not let you put him down. While this could be a normal fearful response, it may also be related to a trigger related to a bad experience with a dog.

Sometimes, it just isn't easy to tell what the cause is.

Consider your current case and ask yourself what potential trauma triggers there might be.

Becoming a trauma-informed Advocate means shifting our view from "what is wrong with this child" to "what happened to this child". When we see behaviors that some may deem 'bad', we can encourage others to consider shifting from seeing this as a bad child with bad behaviors, to a child that has had bad things happen to him.

Many times, Advocates must put on your detective hat to try and understand if a behavior is a trauma response due to a trigger or something else. Here are a few suggestions to help in your investigative work:

- Is the response proportionate to the event? Many times, trauma responses are exaggerated and over the top. So much so, that caregivers may ask themselves, "What is that about?" Exaggerated responses may be a red flag indicating that you are dealing with a trauma response that has been triggered.
- Think about what was happening just before the behavior. You can often gather clues on what might have caused the behavior if you stop and think about the events leading up to it.
- Ask the child. While children may not be able to articulate exactly why they are doing what they are doing, they may be able to tell you what it is not.
- Try to learn as much as possible about the child's history. Talking with the child's social worker, therapist, or birth family may help shed some light on what possible triggers might be.
- Share your observations with other professionals on the case to help shed light on possible triggers.

Adapted from Coalition for Children | Youth | Families, formerly Adoption Resources of WI Recognizing and Reacting to Trauma Triggers
http://wifostercareandadoption.org/Portals/fcarc/TipSheets/AbuseNeglect/TraumaTriggers.pdf?ver=2016-05-16-134757-500

Possible signs that the child has been "triggered":

- Lashes out verbally or physically
- Becomes defiant, disrespectful (fight response meant to keep potential threats at a distance)
- Has difficulty tracking the questions. Shuts down, stops talking
- Becomes jumpy, fidgety, starts pacing. Has sudden, dramatic shifts in mood
- Looks spaced out, gets lost in conversation, or appears to have "gone somewhere else." Speech grows louder, faster
- Suddenly tries to leave situation (flight response)
- Adopts regressive behaviors (thumb sucking, rocking)

Practice Tips to Avoid "Triggering" a Traumatized Child:

- Look for signs of trauma reactions in other situations and avoid those situations if possible.
- Try not to startle the child. Loud noises (including yelling), sudden movements (jumping up from a chair), or unexpected news can all trigger trauma responses.
- Advocate for appropriate parties to prepare the child for what is ahead. Predictability is important to establishing a trusting relationship. Preparation can help minimize the child's hypervigilance to threats from unfamiliar or unexpected sources.
- Minimize initiating touch. You may intend to be supportive when you put your arm around a child, or touch a parent's shoulder, but that can trigger a reaction in people who have been physically or sexually abused. By respecting the individual's personal space, you can help build their sense of control and safety.
- Do not overpromise or tell the child "everything will be fine." This includes promising them that you will always be there for them. Advocates are only involved while the case remains in the court system. Be honest in your communications because children and especially teens may be triggered by feeling let down or misled by their Advocate. Remember that their behaviors may also be influenced by the expectation that you will inevitably disappoint them, so be honest and forthright from the start.

How Trauma Impacts Early Life

As we've explored previously in the toolkit, trauma early in life, when the brain is developing rapidly, can have serious consequences for the normal development of a child's brain, brain chemistry, and nervous system. These changes can place them at risk for learning difficulties, drug abuse, teen pregnancy, risk-taking behaviors, and psychiatric and health problems later in life.

In early childhood, trauma can be associated with the reduced size of the cortex, the ability of brain hemispheres to connect ("cross-talk"), and the functioning of regions of the brain that govern emotions. These changes can affect IQ and the use of thinking to regulate emotions and can lead to increased fearfulness and a reduced sense of safety and protection.

Early Life Trauma: What to Look For

In response to trauma, young children may become passive, quiet, and easily alarmed. They can become more generally fearful, especially in regard to separations and new situations.

In circumstances of abuse by parents or caretakers, young children may act confused as to where to find protection and what constitutes a threat. A child may react to very general reminders of traumatic events, like the sounds of another child crying. The effects of fear can quickly get in the way of recent learning. For example, a child may start wetting the bed again or go back to baby talk following a traumatic event or traumatic reminder. The preschool child may have very strong startle reactions, night terrors, and aggressive outbursts.

How Trauma Impacts School-Age Years

During school-age years, the brain develops more ability to manage fears, anxieties, and aggression, to sustain attention for learning, to allow for better impulse control, and to manage physical responses to danger that allow children to consider and take protective actions. Trauma that occurs during this period can undermine these developing capacities of the brain and result in major sleep disturbances, new troubles in learning, difficulties in controlling

startle reactions, and behavior that alternates between being overly fearful and overly aggressive.

A school-aged child at age 8 facing a first trauma – no matter how distressing – brings more secure neurobiology to that trauma than a child who brings a history of repeated trauma and neglect. The child may develop significant changes in neurobiology and psychology going forward. His expectation of a safe, secure, nurturing responsive world may be shaken by this event and he may need to re-organize his brain and behavior in response to that event. But his early development provides a base for his adaptation to this trauma. Though shaken, this child has a secure foundation to draw upon and is able to use his thoughts (cortex), and positive interventions and supports in the environment, to organize his emotional and physiological responses.

School-Age Trauma: What to Look For

School-age children experience a wider range of unwanted and intrusive thoughts and images. They may think about frightening moments that occurred during their traumatic experiences. They also go over in their minds what could have stopped the event from happening and what could have made it turn out differently. They can have thoughts of revenge that they cannot resolve.

School-age children respond to very concrete reminders (e.g., someone with the same hairstyle as an abuser, or the monkey bars on a playground where a child got shot), and are likely to develop intense, specific new fears that link back to the original danger. They can easily have "fears of recurrence" that result in their avoiding even enjoyable activities they would like to do.

More than any other group, school-age children may shift between shy or withdrawn behavior and unusually aggressive behavior. Normal sleep patterns can be disturbed, and their lack of restful sleep can interfere with daytime concentration and attention.

How Trauma Impacts Adolescence

Throughout adolescence, the maturing brain permits increased understanding about the consequences of behavior; more realistic appraisals of danger and safety; enhanced ability to govern daily behavior to meet longer-

term goals; and increased use of abstract thinking for academic learning and problem-solving. When trauma interferes during this stage of brain development, it can result in reckless and risk-taking behavior, in "living for today and not tomorrow," in underachievement and school failure, and in making bad choices. Because children and adolescents may experience traumatic stress across several developmental stages, they may have a combination of these behaviors.

Adolescent Trauma: What to Look For

Adolescents are particularly challenged by their traumatic stress reactions. They may interpret their reactions as childish or as signs of "going crazy," being weak, or being different from everyone else. They may be embarrassed by bouts of fear and exaggerated physical responses. They may believe that they are unique in their pain and suffering, resulting in a sense of personal isolation. Adolescents are also very sensitive to the failure of family, school, or community to protect them or to carry out justice. After a traumatic event, they may turn even more to peers to evaluate risks and to support and protect them.

Adolescent behavior in response to traumatic reminders can go to either of two extremes: reckless behavior that endangers themselves and others; or extreme avoidant behavior that can derail their adolescent years. Adolescents may attempt to avoid overwhelming emotions and physical responses through the use of alcohol and drugs. Late night studying, television watching, and partying can mask an underlying sleep disturbance.

The Effects on Teen Development and Well-Being

We might also note the following in teens who have experienced trauma:

- It may be harder to forge a trusting relationship, because the young person has not experienced adults as consistently safe.
- Parents and teachers may describe the youth as easily upset, easily provoked, or highly reactive.
- The youth may display what others consider inappropriate emotions and behavior.
- The young person may be triggered by traumatic reminders.
- The youth may be diagnosed as hyperactive, or oppositional, or conduct-disordered.

- The teen may appear inattentive, but he is actually hyper-attentive to "danger signals" of which adults are not aware.
- A common post-traumatic presentation is dissociation. This may be reported as "lying", which actually represents a confabulated reality produced to replace actual events difficult to recall - or "zoning out" which has proven adaptive during traumatic moments.

The table below shows a brief list of possible reactions/symptoms by age: young children (birth to age 5), school-age children (aged 6 to 11) and adolescents (aged 12 to 18).

Age Birth to 5	Age 6 to 11	Age 12 to 18
• Sleep and/or eating disruptions • Withdrawal/lack of responsiveness • Easily startled • Intense/pronounced separation anxiety • Inconsolable crying • Developmental regression, loss of acquired skills • Language delays • Intense anxiety, worries, and/or new fears • Inattention • Increased restlessness, irritability, aggression and/or impulsive behavior • Poor appetite, low weight or digestive problems.	• Nightmares, sleep disruptions • Aggression and difficulty with peer relationships in school • Difficulty with concentration and task completion in school • Emotional swings • Changes in school performance or other social behaviors • Withdrawal and/or emotional numbing • School avoidance and/or truancy • Regression	• Academic problems and/or school issues • Impulsive, reckless and/or self-destructive behavior, e.g., o School truancy o Substance abuse o Sexually acting out o Running away o Involvement in violent or abusive dating relationships • Depression • Anxiety • Withdrawal, from activities or relationships • Numbing, or shutting down emotionally • Anger • Eating disorders • Difficulty imagining future or planning • Range of behaviors such as purposefully pushing buttons, being manipulative, antisocial or aggressive

It is important to remember that these symptoms can also be associated with other stressors, diagnosis, or developmental disturbances, and that they should be considered in the context of the child and family's functioning.

Source: The National Child Traumatic Stress Network, Child Welfare Trauma Training Toolkit – 2nd Edition, www.NCTSN.org.

Being Trauma Informed as a CASA Advocate: Lessons Learned

The Three R's of Trauma-Informed Approaches:

Realizing: Why be Trauma Informed?

Children who have experienced adverse childhood experiences and trauma have learned to be reactive. As a matter of survival, some may have needed to act reflexively before thinking, to take an offensive stance rather than leave themselves vulnerable. Others may have learned to dissociate themselves from the horrors they experienced, to zone out or disconnect from reality, when they were powerless to change it.

We can be reminded to ask the right questions, to interact in a way that will not trigger children's reactivity or cause them to dissociate, and to structure our interactions/visits in a way that will not re-traumatize by reinforcing their sense of powerlessness or shame.

Our Interactions can be Healing…Or can Re-Traumatize

- Many who have experienced trauma have a harder time distinguishing between healthy and unhealthy relationships. Therefore, the issue of trust and betrayed trust will be a major, on-going issue. Relationships worthy of trust are the foundation of progress.
- Appropriate boundaries are key underpinnings of relationships. Because traumatized youth have so little experience with trust, breaking their trust or not following through on a perceived commitment can cause great harm.
- Think about the possibility of past adversity as an underlying problem when you are up against something you don't understand. If you cannot understand why someone does or doesn't do something that seems to be common sense, be curious and ask, "What happened in this person's life that may be influencing this current situation?"
- Offer the child the absolute respect and unconditional love they may never have experienced.
- Do not speak over them. If they are in an escalated state, provide a safe space for them to take a time-out and pass the reactive state. Use

calm tones and space to support them as they move out of their altered state.

- Be an active listener, play back their stories with an outsider's voice. Be unafraid of showing them what is both right and wrong in how to deal with conflict.
- Don't belittle their sensitivity. If it feels real to them, it is real and worthy of a space to be heard and processed
- Allow psychiatric diagnoses to inform your advocacy, but not to define the child. Traumatized youth are often misdiagnosed.
- A calm environment is a safe environment. No matter how stressed you might become, lower the tension in the room to avoid triggering a traumatic memory or creating a perceived threat to safety.
- A traumatized individual may need more physical space. Any sudden moves can be misinterpreted as an attack, an encroachment on personal space can trigger a memory of being trapped.
- Body language is critical to maintaining a sense of safety. Traumatized youth will react to being judged and are hypervigilant to any perceived threat.
- Traumatized youth will often react before thinking about consequences, largely because the part of their brain that fires in response to threat reacts instantly. Activation of the reasoning, judging, and evaluating parts of the brain happens later and only then may the young person be able to inhibit their instantaneous reactions, but by that time it may be too late. In any situation where the young person is frightened, upset, or angry it is better to create a safe space where the youth can retreat and take the time needed to calm down.

Remember:

When we are trauma informed, we shift from a stance of "What's wrong with you?" to "What happened to you?"

When we are trauma informed we are respectful and minimize the possibility of triggering their reactivity.

When we are trauma informed we understand what is about us and what is not about us. When we do not interpret mistrust, reactivity, or anger as personally

directed, we can respond with empathy rather than defensiveness.

When we are trauma informed we learn to "hold" others' pain in a supportive way rather than to "own" it.

When we are trauma informed and work with youth who have endured unbearable lives, we often find that in sharp contrast to them being "damaged" or "broken," they are sensitized and fully committed to making others' lives better.

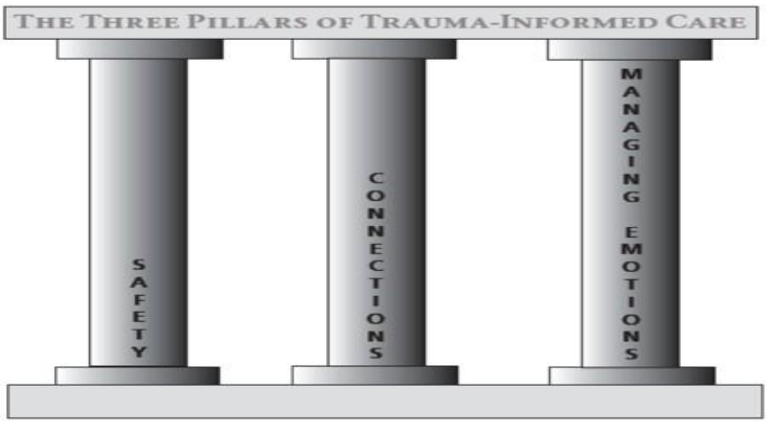
For more information, learn about The Sanctuary Model. http://www.sanctuaryweb.com/sanctuary-model.php

Adapted from: **Trauma Informed Practice: Working with Youth Who Have Suffered Adverse Childhood (or Adolescent) Experiences** written by Sandra L. Bloom, Zeelyna Wise, Joseph Lively, Marcos Almonte, Stephanie Contreras, and Kenneth R. Ginsburg. In "Reaching Teens: Strength-Based Communication Strategies to Build Resilience and Support Healthy Adolescent Development" Elks Grove Village IL; American Academy of Pediatrics; 2013.

The Impact of Trauma on the Advocate-Child Relationship

Trauma can interfere with the formation of strong advocate-child relationships by impairing the child's capacity to trust others, process information, communicate, and respond to stressful situations. Advocates who understand trauma's impact on behavior can use that understanding in their approach with traumatized children. For example, the Advocate can explain to the child the court proceedings in a way that reduces their likelihood of a traumatic response and can advocate for the child in a way that empowers them and helps build a sense of safety and resiliency. With adequate preparation, a child may feel empowered by the opportunity to tell their stories and receive empathy and effective support from the professionals involved.

To establish an effective working relationship with a traumatized child, focus on the three pillars of trauma-informed care: physical and psychological safety, emotional management and communication, and connection and support.



Physical and psychological safety:

When a child is reminded, either consciously or unconsciously, of a past trauma, that trigger may cause the child to feel as if he/she is in imminent danger. When traumatized children feel physically or psychologically unsafe, they may become focused on protecting themselves and avoiding the perceived danger. As a result, they may not listen to or process information accurately, may refuse to talk, or may simply agree to anything in order to leave. You can establish a safe environment by providing structure and predictability, allowing the child to share their views and make informed decisions about his or her case whenever applicable and possible.

Court hearings and other procedures in the child welfare system may inadvertently trigger or re-traumatize children with trauma histories. For example, children can frequently be triggered by a perceived loss of control or power, such as court decisions made about placement or visitation. Therefore, giving children a clear voice in decisions related to their representation, eliciting their views, and seeking active, age-appropriate involvement is an important recommendation to heed.

When triggered, children may react in ways that are misinterpreted by the court. For example, a child may withdraw emotionally or physically *(often described as freezing or shutting down)* in response to questions about

desire for contact with a parent. Or, as a different example, a parent with a trauma history may shut down or react defiantly during questioning. A child placed in foster care, particularly an adolescent, may run away or act out in response to conflict with a foster parent or group home staff member. Judges, attorneys, caseworkers and service providers may view such a child as uncooperative or disinterested rather than as someone who is having a trauma response. You can advocate for the child by sharing with others, as appropriate, that the child's behavior may be a reflection of underlying trauma.

Suggestions for Increasing Physical and Psychological Safety:

- Meet in a quiet space where there are minimal distractions, away from other parties who may make the child feel threatened.
- Inform the child in an age-appropriate way the purpose for the meeting and/or court hearing, what to expect during the meeting/ hearing, and your understanding of approximately how the long it will last. Make sure to ask what questions they may have so you can advocate for those questions to be answered.
- Explain what you are going to say in the meeting or to the judge during a court hearing, so the child knows what to expect. This can help the child feel less anxious during a hearing and increase their ability to respond accordingly and have a sense of control and safety.
- It is empowering to the child to feel that their Advocate is listening to them and will express their wishes to the court. It is also important for them to be prepared to the extent possible on any outcomes from the meeting or hearing.

Additionally, when children are not present for court hearings, it can be triggering for them to know there was a court date but not be informed about what happened at that hearing. Children and youth should attend their own hearings whenever possible. When their presence is not possible, it is important to provide information about what happened or some type of update in an age-appropriate manner.

Managing Emotions and Communication:

Children who have experienced trauma may experience greater difficulty forming a trusting relationship with their Advocate. Many have been hurt by a caretaker or authority figure they trusted. The child may not believe that you will actually advocate for them. They may also be slow to share emotionally-charged information or may not feel safe expressing preferences regarding their desired outcomes, such as visitation or placement. Developing an effective advocate-child relationship takes time and patience.

You can also learn to recognize signs that a person may be experiencing a trauma trigger or trauma reaction during your communication with them so that you do not misinterpret or exacerbate their response. A child who suddenly becomes loud or combative during your time together, may be going into "fight mode" in order to keep herself safe by pushing others away. Children may go into "flight mode" and try to avoid a triggering situation by refusing to answer questions or attempting to leave your visit, the meeting or court hearing. Children may also "freeze" by shutting down or dissociating *(a response to trauma when a person mentally shuts down or "goes elsewhere")*. She/he may sit quietly but will no longer be paying attention. Do not assume that silence means the child understands or is in agreement with something when this occurs.

Children can also learn how to manage their emotions and impulses which are essential skills for healthy development when communicating with an Advocate. Their Advocate can be a role model on how to regulate feelings during emotionally charged situations.

Connection and Support

Parents and children who are involved in the child welfare system may still have strong attachments to, and pleasant memories of, family members. In fact, a child can remain emotionally attached to a dysfunctional family and may be further traumatized by complete loss of contact with relatives. Family members can offer the best source of long-term support for a traumatized child. It is essential that a child stay connected with siblings, relatives and extended family (as defined by the child), and friends. In cases in which ongoing family contact is not feasible or is contraindicated for safety reasons, you can look for ways to involve other people trusted by the child, such as a family friend, coach, teacher, or pastor.

The positive quality of the child's connection with you, their Advocate, is also an important piece of the trauma informed advocacy practice. Finally, you should be aware that some children may find the experience of court involvement traumatizing, whether from memories of past involvement, interactions with or observations of others in the courthouse, and especially the intensity of the courtroom environment itself. Trauma triggers might include an attorney's behaviors, tone of voice, body language or approach to questioning. You can take advocacy steps to ensure others are doing their part in making the child feel more comfortable and to recognize when they are having a trauma reaction.

Excerpt taken from: National Child Traumatic Stress Network, Justice Consortium Attorney Workgroup Subcommittee (2017). Trauma: What child welfare attorneys should know. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Activity: Please watch the 2-minute video, *"Relational Trauma: What the Adults Should Know"* from the Child and Parent Resource Institute. http://www.acesconnection.com/clip/relational-trauma-what-the-adults-should-know

As we've mentioned previously, the parents of the children we are advocating for are often adults parenting with their own trauma histories. This trauma history impacts all of their adult interactions with the system, in similar fashion to how trauma impacts a child's perception and interactions with others. Remembering that part of being a trauma-informed Advocate includes understanding that the parent may be doing the best they can, with the trauma history or ACEs score they bring to their role.

For more information, request the independent study in-service training *Working with Parents with Trauma.*

Communication, Court Environment, and Self-Awareness for All Parties to the Case:

What Hurts and What Helps?

	What hurts?	What helps?
Communication	**Interactions that are humiliating, harsh, impersonal, disrespectful, critical, demanding, and judgmental.**	**SHOW RESPECT. Interactions that express respect, kindness, patience, reassurance, and acceptance.** • Instead of talking at the person by saying,"Let me give you some advice," talk with the person by saying, "What do you think?" or "What can we do to solve the problem?" • Use "please" and "thank you" frequently. • Use the name of the people before you, addressing them by their surnames proceeded by "Mr." or "Ms." • Ask the person before you if he or she has any questions. • Use short encouraging statements such as: "Your commitment really shows;" "It's clear you are trying to change;" "Despite what happened in court last time, you have been able to…" • Provide praise that is concrete, specific and delivered with a neutral tone. "I heard that you earned a one-month token in AA. I know you worked hard for that." "I read in the court report that you followed last month's visitation schedule without any problems. This will help your child." • Instead of, "The court/DHS is sending you for a mental health evaluation," try "We'd like to refer you to a doctor who can help us better understand how to support you."
	Distracted listening.	**LISTEN. Use active listening.** • Maintain eye contact. • Listen without judgment. • Examine your body language. Are you conveying attention? • Also, pay attention to the speaker's body language. This is a facet of true listening. • While listening, do not plan what you will say next. Think only about what the person is saying. • Provide regular feedback by reflecting and paraphrasing the content. For example, "I can see you are confused," or "Sounds like you are saying…"

	Thinking and/or asking, "What's wrong with you?"	**UNDERSTAND. Think and ask: "What has happened to you?"** • Recognize that some behaviors (hypervigilance, dissociation, avoidance) can be self-protective coping strategies; the trauma "symptoms" may be adaptations. • Instead of discussing sensitive issues related to trauma in open court advocate for the attorneys and parties to approach the bench and conduct a sidebar conversation.
	Becoming aggressive and hostile when confronted with aggression and hostility.	**REMAIN CALM. Use a quiet tone of voice and a slow pace of speaking that encourages stability and physiological regulation.** • Recognize that the displayed anger could be increased activation of the arousal systems associated with survival, that the behavior could be self-protective, and that victims of trauma can often over-exaggerate the "threat." This doesn't justify the behavior, but it can provide insight; insight leads to compassion and problem-solving. • Gently name the person's behavior in a nonjudgmental way. For example, say, "I can hear how upset you are." • Ask questions to clarify the issue. This shows a willingness to understand. However, avoid "why" questions and use "what" or "how." Use active listening as mentioned above. • If necessary, advocate for a recess to be called to allow the person an opportunity to self-regulate. • Do not threaten; inform of consequences.
	Allowing court processes to be unknown and unexpected.	**BE TRANSPARENT. Use clear, simple language to let people know what is happening and why.** • Explain the purpose of each hearing and who is in the courtroom. • Use non-technical language. • For example, instead of conducting sidebar conversations without explanation, tell the person that a sidebar conversation will occur and why – saying, "We have to discuss some issues related to your case. We just need a minute to do it on the side."

Court Environment	**Congested, noisy waiting areas.**	**Reduce stress prior to the hearing by offering a calm and quiet space to wait.** • Advocate for a well-maintained and clean waiting area and facility. • Notice the lighting and temperature and advocate for it to be adequate and comfortable. • Ask for security staff to be present in the waiting areas if necessary.
	Congested, noisy courtrooms.	**Ensure that the overall noise level of the courtroom is kept to a minimum, along with the level of movement and activity.** • Advocate for a well-maintained and clean courtroom. • Notice the lighting and temperature and make sure it is adequate and comfortable. • Keep the noise limit low enough so that the noise is not distracting and provides a calm environment.
	Confusing signage.	**Reduce anxiety prior to the hearing by offering clear directions to the courtroom and posting simple courthouse rules.** • Walk through the courthouse and notice if signage is clear. Are there courthouse maps that are easy to read? Are the courtrooms clearly labeled? Is signage in multiple languages needed? • Are simple rules about noise and courtroom decorum posted and easily understood?
	Not feeling safe and secure.	**Advocate for adequate courthouse security and ensure safety in the courtroom.**
	Long periods of wait time before appearing before the judge.	**Advocate to institute time-specific docketing to reduce anxiety and agitation.**
	Vast physical distance between the judge and the parties.	**Consider conducting family court hearings at a table.**

	An elevated bench between the judge and the parties.	**Move from behind the bench and instead sit at the head of a table.**
	Intimidating behavior by the bailiffs.	**Eliminate forms of non-verbal intimidation (jingling handcuffs or keys).**
	Recalling traumatic events, memories, and feelings in open court.	**Use caution when questioning about traumatic events. Consider having a trained mental health professional on-site to debrief with families and children after court.**
Self-Awareness	**Personal bias.**	**Be vigilant in your awareness of your own personal biases as it can alter your perception of the impact of trauma.** • Take note of any "baggage" you hold from your own traumatic experiences or trauma events experienced by loved ones. • Identify your potential biases and how they might color your interpretations without your even being aware of it. • Understand and appreciate the culture, race, ethnicity, economic situation, religion, and place of residence of court-involved families. • Ask whether proposed case plans/probation sanctions /visitation orders are reasonably tailored to the specific needs of the child and family. Research has shown that many parents need practical help, but this kind of assistance is not always a priority. • Be open to and encourage appropriate connections to religious, community, and cultural institutions. • If you are working with a youth or adults whose sexual orientation differs from yours, get training to understand their needs and how the system might affect them.

Chart: http://www.flcourts.org/core/fileparse.php/517/urlt/Whathurtsandwhathelpscontinuous.pdf

Source material:

- *Using Trauma-Informed Practices to Enhance Safety and Security in Women's Correctional Facilities*, National Resource Center on Justice Involved Women, Alyssa Benedict
- *Essential Components of Trauma-Informed Judicial Practice*, Substance Abuse and Mental Health Services Administration
- *Safeguards Against Bias*, National Court Appointed Special Advocate Association
- *Pasco County Circuit Court Trauma Audit*, National Council of Juvenile and Family Court Judges

Resources

Harvard University's Center on the Developing Child
This website offers information regarding the key concepts related to brain development (brain architecture, serve and return, toxic stress, executive function) and a listing of multimedia, reports, briefs, and working paper resources.

Centers for Disease Control and Prevention's ACE Study Site
This website offers general information about the study, related links, and major findings.

Centers for Disease Control and Prevention Child Development Site
This site offers general information on development, milestones, and developmental screening. It also hosts positive parenting tips, research, scientific articles, and information on children's mental health.

The National Child Traumatic Stress Network
This site offers information about different types of trauma, resources, various trauma topics, trauma curricula, and evidence-based treatment fact sheets. The network also provides a monthly electronic bulletin featuring the latest research and upcoming events.

National Council of Juvenile and Family Court Judges
This link provides trauma principles, definitions, resources, and tools for judges.

ACES Too High
This site provides trauma-related information in a variety of categories and features trauma-related work from across the country.

CASA, The Judges' Page Newsletter, Trauma Edition
This 2015 edition of the newsletter from National Court Appointed Special Advocates provides a series of trauma-related articles authored by several judges, including Judge Lynn Tepper from Florida's 6th Judicial Circuit.

National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development
This center features trainings, webinars, and resources.

Substance Abuse and Mental Health Services Administration's Concept of Trauma and Guidance for a Trauma-Informed Approach
Published in July 2014, this document presents key assumptions and principles for a trauma-informed approach and provides guidance for implementing such an approach.

Substance Abuse and Mental Health Services Administration
This link provides information on what is meant by a "trauma-informed approach" and lists well-known trauma-specific interventions.

American Institutes for Research: Trauma-Informed Care
This website provides comprehensive information about trauma-informed care, including a series of webinars that address the impact of trauma on veterans.

Section Two: Building Resiliency Through Protective Factors

A complete consideration of ACEs and trauma requires the addition of balancing elements of hope and healing which can occur for a child and a family so that they thrive. This hope and healing directly comes from building resiliency through acquiring or increasing the individual's and families' protective factors.

It should be noted that despite trauma histories and traumatic stress reactions, children are often resilient. Your actions during the course of your advocacy efforts can further bolster resiliency. This could be through advocacy for trauma-informed treatment or facilitating a child-advocate relationship that conveys awareness of traumatic stress reactions, promotes a psychologically safe environment, and directly advocates for protective factors to be nurtured – all can support the child's improved future.

What About Resilience?

Resilience is the ability to thrive, adapt and cope despite tough and stressful times. It is the natural counter-weight to ACEs. The more resilient a child is, the more likely they are to deal with negative situations in a healthy way that won't have prolonged and unfavorable outcomes. While there may be personal attributes that contribute to resilience, it is not a quality specific to an individual ("He is a resilient little fellow"). Thus, resilience is not an innate characteristic, but rather is a skill that can be taught, learned and practiced. Everybody has the ability to become resilient when surrounded by the right environments and people.

"Resilience does not mean that children 'get over it.' It does mean that the caring adults in their lives have a lot of power to buffer, rather than cement, the effects of toxic stress."

Amanda J Moreno, Ph.D.
Erikson Institute

Activity: Please watch the 2-minute video, *"What is Resilience?"*** from the Center on the Developing Child

https://youtu.be/cqO7YoMsccU

How do we support building resilience?

Toxic stress is a chronic activation of a physiologic response to stressors when there is no buffering protection, or support. Supportive relationships and active skill-building strengthen the foundations of resilience which offer hope and healing to a traumatized child.

Activity: Please watch the 2-minute video, *"The Science of Resilience?"*** from the Center on the Developing Child.

https://www.youtube.com/watch?v=1r8hj72bfGo

The presence of a caring, stable adult and being raised in a safe, stable and nurturing environment are two critical factors to build resilience. In fact, **research is now showing that the presence of supportive relationships is more critical than the absence of ACEs in promoting well-being.**

If parents are struggling, other adults – like teachers or coaches – can be present to provide the safe, stable, nurturing relationships that a child needs. We can also invest in community supports that strengthen the families to set them up for future success.

"We need a two-generation approach recognizing that the child is experiencing ACEs now and the parent likely experienced ACEs during their own early years."

Angelo P. Giardino, M.D., Ph.D.
Texas Children's Hospital

Activity: Please watch the 2-minute video, *"How Resilience is Built"*** from the Center on the Developing Child.

https://youtu.be/xSf7pRpOgu8

Learning how to be resilient isn't just for children – adults can learn these skills as well. Two main approaches that are effectively being used are *working with parents directly* and *intervening early with children who have experienced toxic stress.*

"We need to do more than give parents information and advice: we need to build their capabilities."

Dr. Jack Shonkoff
Harvard University

"By using techniques to allow them [children] to express what their worries are and their stress, to lower their experienced stress, we are going to be able to help them maintain their resilience. And that's our goal."

Dr. David Johnson, Clinical Psychologist
Post-Traumatic Stress Center

A third approach to improving resiliency is to expand the understanding and applicability of the Adverse Childhood Experience (ACEs). The Iowa Child Advocacy Board is committed to this approach by training our CASA Advocates on ACES, trauma, and resiliency, and by tracking ACEs and protective factors across the cases we serve on.

"If [people] already know that these [ACEs] are common, they are more likely to be relieved, I think, than frightened...they don't feel alone anymore. That 'I'm not the only one that experienced these kinds of things.'"

Dr. Robert Anda
Centers for Disease Control and Prevention

Promoting Resilience in Child Welfare Practice

In the past, child welfare case work approached helping families by using different terminology: helping through the alleviation of risk factors, regular monitoring for and treatment of vulnerability factors, and the provision of environmental protective factors. For example, a child who has come to the attention of child welfare has been exposed to risk factors, abuse and/or neglect, that challenges the child's ability to achieve and maintain well-being and be kept safe. One of the roles of child welfare case practice is to ensure that children have the family and community resources that can serve as protective factors in resilience – a caring adult, appropriate educational opportunities, and a safe concerned caregiver. In addition, by screening for mental health needs as part of an overall case practice it is possible to identify vulnerability factors early so that they can be addressed as soon as possible, allowing the child to access the resources that the system has made available.

Resilience: Think Adversity, Vulnerability and Protective Factors

Adversity refers to negative life circumstances that are known to be associated with adjustment difficulties. Risk factors include poverty, chronic exposure to community violence, family chaos, illness, and substance abuse. Vulnerability factors are those internal factors that may exacerbate the effects of risks – for example, developmental challenges or a mental illness which may exacerbate the effect of community risk factors for a child. Protective factors are things that can modify risks in a positive direction, and include coping skills, caring relationships, positive expectations and opportunities for meaningful participation in the environment.

As you can see, everyone in the system is working towards the same end goal: children being kept safe and having positive well-being, living a life where they can thrive.

Source: Fraser, M. W., & Terzian, M. A. (2005). Risk and resilience in child development: principles and strategies of practice. In G. P. Mallon & P. M. Hess (Eds.), Child welfare for the 21st century: A handbook of practices, policies, and programs (pp. 55-71). New York, NY: Columbia University Press.

A Protective/Promotive Factor Framework

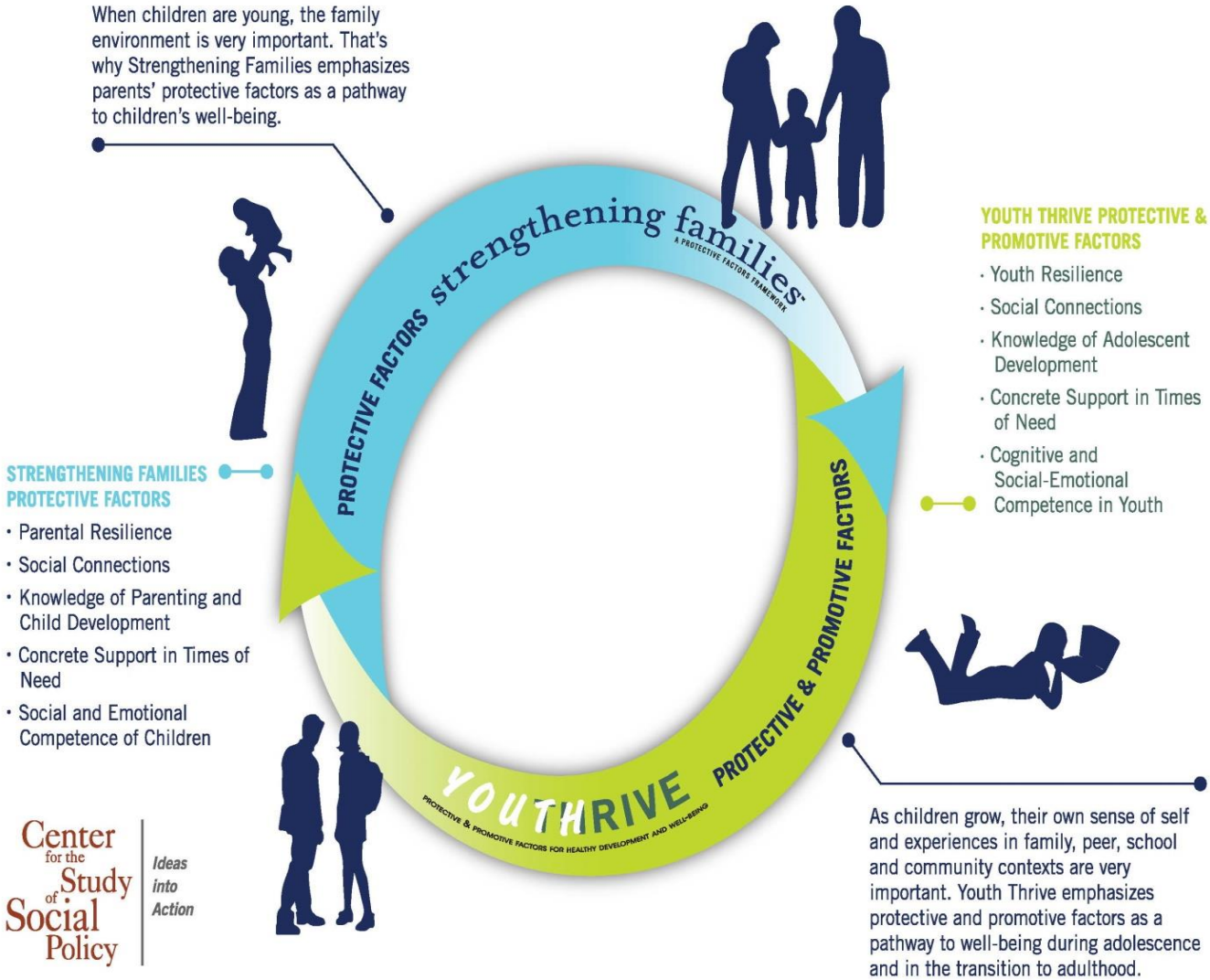
The Center for the Study of Social Policy (CSSP) leads two initiatives based on parallel frameworks of protective factors: *Strengthening Families* (for families of young children) and *Youth Thrive* (for youth and their families and caregivers). The first step in developing the *Strengthening Families* approach was to thoroughly investigate what the research tells us about reducing child maltreatment – about what is *right* with families that protects against child abuse and neglect. CSSP worked intensely with researchers and advisors to identify a set of protective factors that are shown to reduce the likelihood of child abuse and neglect.

Protective factors are the conditions or attributes of individuals, families, communities or the larger society that mitigate risk and promote healthy development and well-being. Put simply, they are the strengths that help to buffer and support families at risk. We now know that changing the balance between risk and protective factors so that protective factors outweigh risk factors is an effective prevention and intervention strategy. Helping children, youth and families build resilience and develop skills, characteristics, knowledge and relationships that offset risk exposure can contribute to both short- and long-term positive outcomes.

Focusing exclusively on risk factors with families can leave families feeling stigmatized or unfairly judged. On the other hand, using a protective factors approach can be a positive way to engage families because it focuses on families' strengths and what they are doing right. A protective factors approach can also provide a strong platform for building collaborative partnerships with other service providers—like child care providers—that are not as familiar or comfortable with a risk paradigm as a basis for engagement with families.

Recently, the terminology of promotive factors has also entered the picture. Promotive factors go beyond just protecting against risk or bad outcomes to actively promote a healthy outcome. Research shows that the protective factors identified by *Strengthening Families* actually serve as promotive factors, as well. This is because the research behind Strengthening Families identifies characteristics of families that increase the likelihood of optimal

development for children (a promotive function) while simultaneously reducing the likelihood of child maltreatment (a protective function). When the Protective Factors Framework was first developed, the idea of promotive factors was not yet on the table. Today it can be said that the framework is based on factors that are both protective (of child abuse and neglect) and promotive (of children's optimal development).



What does this mean in the CASA Advocacy role?

By viewing our advocacy efforts through a protective/promotive factor lens, we also increase our ability to transform relationships with parents. Perceiving parents as partners in the process of creating change so they can be the best parents they can be and improve the outcomes of their children is a positive lens to use in our advocacy role.

A trauma-informed lens can help us help caregivers respond to a child's trauma signs and symptoms. Whether they are in a parenting role or another caregiving role, adults who care for children who have experienced trauma are likely to face specific challenges. The protective factors framework can help us, *as CASA Advocates,* to understand what those challenges are and identify potential supports.

Caregivers may experience specific challenges when parenting children who have experienced trauma:

- More externalizing behaviors and "testing" of caregivers
- Fewer positive responses to caregivers
- May not respond well to typical disciplinary approaches

NOTE: Caregivers may include birth parents, foster parents, adoptive parents, kinship caregivers and other adults (e.g., child care provider, grandparent)

Let's take a look at how a child's manifestation of trauma can impact the presence or strength of each individual protective factor, and the caregiver's ability to build each protective factor, both in their own lives and the lives of their children. For each protective factor, we will also look at what we can do to support these caregivers to provide the best possible care for their children.

Protective Factor 1: Parental resilience – Through a trauma lens

What is it? Managing stress and functioning well when faced with challenges, adversity and trauma.

- Because trauma can impact a child's affect and responsiveness, caregivers may not get the positive feedback which helps to build parental resilience.
- Stress in the parenting relationship may undermine personal resilience as well.
- Particularly for caregivers who feel some responsibility for the trauma their children have experienced, resilience is challenged.
- Caregivers may need extra support building confidence in their parenting skills and focusing on self-care in the face of children's post-traumatic behavior.

Recall the important concept from learning about trauma related to child development called serve and return – it is about the interaction between children and their caregivers. When a caregiver smiles, a baby smiles back, which elicits a response from the caregiver. We've discussed how trauma can impact a child's affect and responsiveness. This means that a traumatized child might not always give a caregiver the positive, loving feedback that helps build parental resilience. This stress can undermine personal resilience as well, since it's often hard to feel good on a personal level when you're not receiving positive feedback from a loved one.

Some of the caregivers we work with feel responsible for the trauma their child experienced, which presents additional challenges for the parent – and for us, if we are concerned about the child. Often, we need to provide support to a parent or other extended member who could have protected or buffered the child but didn't for whatever reason.

In the child welfare system, we will often be working with parents who have been reunited with their children after abusing or neglecting them. These parents may be especially lacking in their sense of being an effective parent – which is only compounded if the child's behavior becomes more challenging after the traumatic experience. These parents need special support to build that resilience up at the same time as we help them build the other protective factors that will help them make better decisions in the future.

As CASA Advocates, we must recognize that parenting a child who has experienced trauma can be extremely difficult and stressful for caregivers. However, it is incredibly important that caregivers don't "give up" on their child at a time when the child needs them most. To prevent caregiver burnout, we need to ensure that caregivers are provided extra support in effectively building their confidence around their parenting skills. It is also helpful to recommend services that assist caregivers in developing self-care strategies to help them remain personally resilient in the face of the child's challenging post-traumatic behavior.

Protective Factor 2: Social connections – Through a trauma lens

- Caregiver may have difficulty engaging social networks when others don't understand trauma and its impacts on behavior.
- Caregiver may have difficulty making or keeping relationships with parenting peers or others who could support their caregiving because of children's externalizing and internalizing behaviors.
- Caregivers may need support to develop new social connections and mutual support networks among parenting peers in similar situations.
- Caregivers may need tools for educating their extended family and other social connections about trauma.

When children's post-traumatic behavior becomes particularly challenging, caregivers may have subsequent difficulties with their own social relationships. The caregiver can feel isolated because other parents might not understand the child's behavior or might not appreciate trauma-informed caregiving strategies. All of this can impede the caregiver from engaging in and/or maintaining a positive social network with supportive peers.

To prevent these experiences of social isolation, it's important, *as CASA Advocates,* to recommend services that will help caregivers understand how to frame the child's trauma and create empathy for the child's behavior when communicating with other adults. By bridging the trauma-knowledge gap, a caregiver becomes more likely to build positive, supporting social connections with others.

In addition, caregivers of children who have experienced trauma can often benefit from connecting with others who are in similar circumstances. *As CASA Advocates,* we can support them in finding and building relationships with others, through support groups or informal introductions, and encourage them to find ways to support each other in their parenting.

Protective Factor 3: Knowledge of parenting and child development – Through a trauma lens

- Caregivers who are not aware of trauma and its impacts may misinterpret child's behavior and respond in unproductive ways.
- Advice available about typical child development and behavior is unlikely to help.
- Caregivers may not be able to draw on their own past parenting experiences to help them with this particular child.
- In addition to more universal knowledge about child development, caregivers may need extra support understanding how trauma impacts development and the extra nurturing children need when they have experienced trauma.

As mentioned earlier, in terms of knowledge of parenting and child development, caregivers that are not aware of trauma and its impact may misinterpret the behavior of traumatized children. These caregivers are unlikely to find solutions if they turn to standard parenting advice or rely on their past parenting and child care experiences.

In addition to more universal knowledge about child development, caregivers in these cases may need extra support in understanding how trauma impacts a child. Specifically, caregivers need to be taught how to appropriately interpret children's symptoms and be prepared to provide sensitive, nurturing care. *As CASA Advocates,* it is important to make recommendations for such trauma-informed services.

Protective Factor 4: Concrete support in times of need – Through a trauma lens

- Caregiver may need access to specific therapeutic supports to help the child with healing.
- Caregiver may need formal or informal respite care arrangements that can accommodate the child's special needs.
- Manifestations of trauma may disrupt daily events and have negative impacts on ability to work, get child care, etc.

Caregivers may need additional concrete supports to help their child with healing, as well as to other supports to address issues like externalizing behaviors. *As CASA Advocates, w*e can support the caregiver by referring them to a trusted agency and making a warm hand-off between the caregiver and provider at the time of the referral.

Another concrete support many caregivers may need is respite care arrangements. As mentioned in the context of social connections, a parent's typical social supports may not be equipped to provide the right kind of care to the child – or may not be willing to care for a child who is acting out. Through mutual support networks or formal programs, caregivers should have at least one trusted alternate caregiver so that they can get a regular break, accomplish things they need to do and take care of themselves.

This is particularly true when the child's manifestations of trauma disrupt the caregiver's daily routine. For example, a child's behavior problems can make it difficult to find or maintain child care; frequent calls from the school and need for therapy and medical appointments can make it difficult for the caregiver to work on a regular schedule. Additional concrete supports may be needed for the caregiver in these circumstances.

Protective Factor 5: Social and emotional competence of children– Through a trauma lens

- Supporting children's social and emotional development is more complex and challenging for children who have experienced trauma.

- Young children who have experienced trauma will need extra support for their social and emotional development.
- Caregivers must understand how trauma impacts social and emotional behavior and be equipped with appropriate strategies.

Supporting children's social and emotional development is more complex and challenging in cases where the child has experienced trauma. Young children who have experienced trauma will need extra support for their social and emotional development. It is key that caregivers understand how trauma impacts this development and are prepared to respond accordingly. *As CASA Advocates*, we can make recommendations for caregivers to received education about trauma and its impact on children's social and emotional development.

Additional Resources

Other tools to support and nurture resiliency are growing rapidly as we learn more about effective means to improve the lives of children who have experienced ACEs. For example, The Robert Wood Johnson Foundation and Sesame Street are partnering to help families cope with traumatic experiences and foster nurturing connections between children and the caring adults in their lives. Sesame Workshop has developed a series of tools and resources to build coping skills and foster nurturing connections between children and the caring adults in their lives. These new materials are part of Sesame Street in Communities and include videos, storybooks, and digital activities that are research-driven and produced in consultation with experts in childhood development, brain development, and trauma. These tools highlight strategies used by social workers, therapists, health care providers, and educators, which—combined with the consistent presence of caring adults—are proven to lessen the impact of traumatic experiences on young children.

Visit SesameStreetinCommunities.org to explore these new resources, access free tips, videos, and professional development tools, and spread the word to families and providers who work with children.

Final Step to Trauma-Informed Advocacy: Self Care

Every one of us that is connected to the child welfare system in some capacity benefits from practicing good self-care. The benefits range from being stronger, healthier individuals, having an increased capacity to create a positive impact on the world around us, to directly improving the outcomes of the children we serve by being better at maintaining our objectivity and offering effective recommendations that improve the well-being of the child. In essence, we are stronger in being “the voice of the child” when we take care of ourselves.

The Iowa CASA program takes our responsibility of supporting our Advocates seriously. We want to partner with each Advocate in the development of their advocacy role by providing intentional training on self-care. For that reason, we will provide separate training modules specific to the goal of Advocate well-being, self-care and reducing the impact of vicarious trauma.

This is the end of the independent study portion of this module. Please complete the evaluation and send it along with your online certificates to your coordinator. Your coordinator will schedule time to discuss how you will apply this content to your assigned case. In addition, we will provide you with “Monitoring a Case” module, part of the first year required training series, that will further build upon the resiliency material covered in this training.

Thank you for your efforts in completing this content to become a trauma-informed Advocate to build resiliency in the children we serve.